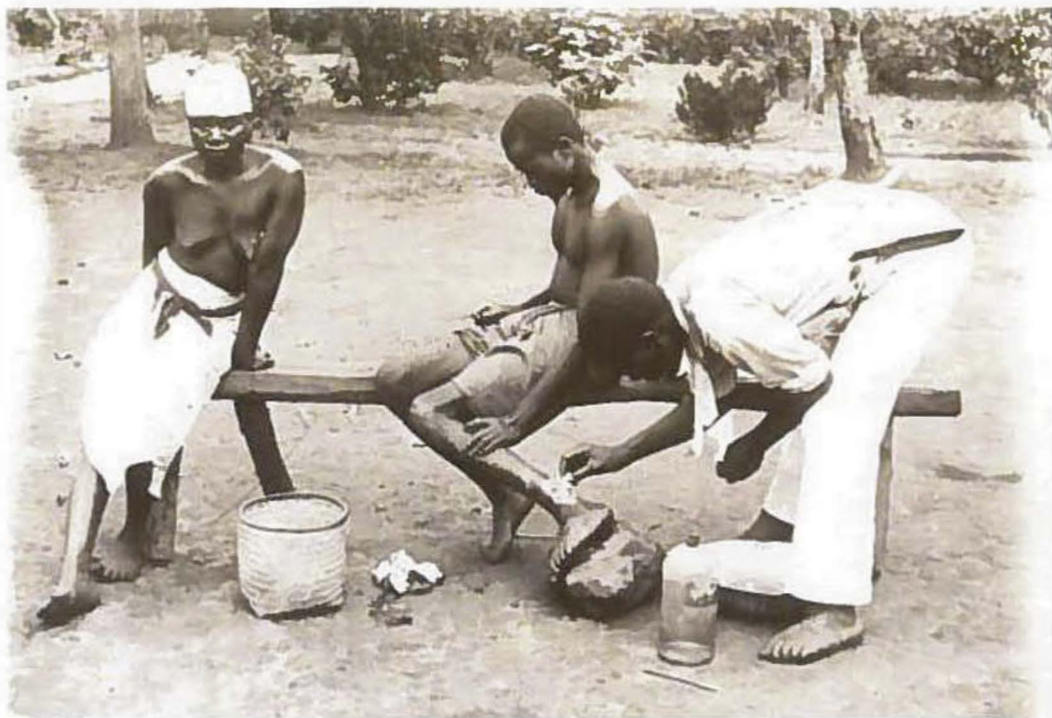
JYVÄSKYLÄ STUDIES IN HUMANITIES

62

Markku Hokkanen

Quests for Health in Colonial Society

Scottish Missionaries and Medical Culture in the Northern Malawi Region, 1875-1930



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UNIVERSITY OF JYVÄSKYLÄ

JYVÄSKYLÄ 2006

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ABSTRACT

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This study discusses medical culture, colonialism and Christian mission in South-Central Africa through the case-study of the Livingstonia Mission of the Free Church of Scotland in Malawi between 1875 and 1930. It explores ideas, practices and experiences of illness, health and medicine among missionaries, Africans and secular colonialists in the Northern Malawi region. Both the missionary search for health in African conditions, and the African quest for health and healing within Livingstonia and the emerging Presbyterian Church are explored.

High mortality rates among pioneer missionaries and the experience of living and working in an "alien" environment influenced missionary thought and practice at Livingstonia under the leadership of Dr Robert Laws. There was an attempt to impose order on missionaries, Africans and the environment in line with Laws' theory of "holistic health". In matters of public health Livingstonia often co-operated closely with the British colonial authorities. Hygiene and public health could be used to legitimise missionary and colonial acts of power.

Improvements in missionary health at the turn of the century, largely due to improved living conditions and the emergence of "tropical medicine" were in contrast to the experience of the general African population for much of this period. Changing disease patterns, the establishment of the colonial economy and the effects of the First World War all had a detrimental effect upon African health. Missionary medicine was not a viable therapeutic alternative for the majority of the population, who continued to rely upon the existing fluid and pluralistic African medical culture. Inequalities in health provision between Europeans and Africans became a salient feature of the colonial society.

In missionary publications mission medical work was often presented as part of a struggle between the "light" of Christian medicine and the "darkness" of "pagan superstition". Unpublished missionary publications reveal a much more rich and complex history of therapeutic encounters and exchanges. Missionary attitudes towards, and experiences of medicine in Africa were less uniform than the published material would often suggest. Equally, African experiences of, and responses to an "alien" medical and health culture were diverse: committed African Christians were not passively "obedient" any more than those outside the church were uniformly "hostile". African "middles" (interpreters, assistants, nurses, evangelists) were vital to "negotiations" over therapy between medical missionaries and African patients, therapy managers, elites and healers. Debates and discussions within the Presbyterian Church reveal that groups of African Christians found ways to contest missionary attempts to establish hegemony over health and healing. Similarly, in the local Native Associations the African elite identified health threats wrought by colonialism and "civilization". A distinctive Christian medical pluralism was one of the major legacies of the contacts between the Scots and Malawians during the colonial period.

Keywords: African studies, Christian missions, colonialism, health, history of medicine, Malawi, Scotland.

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Honkasaari, Lieksa – Jyväskylä, August 2006
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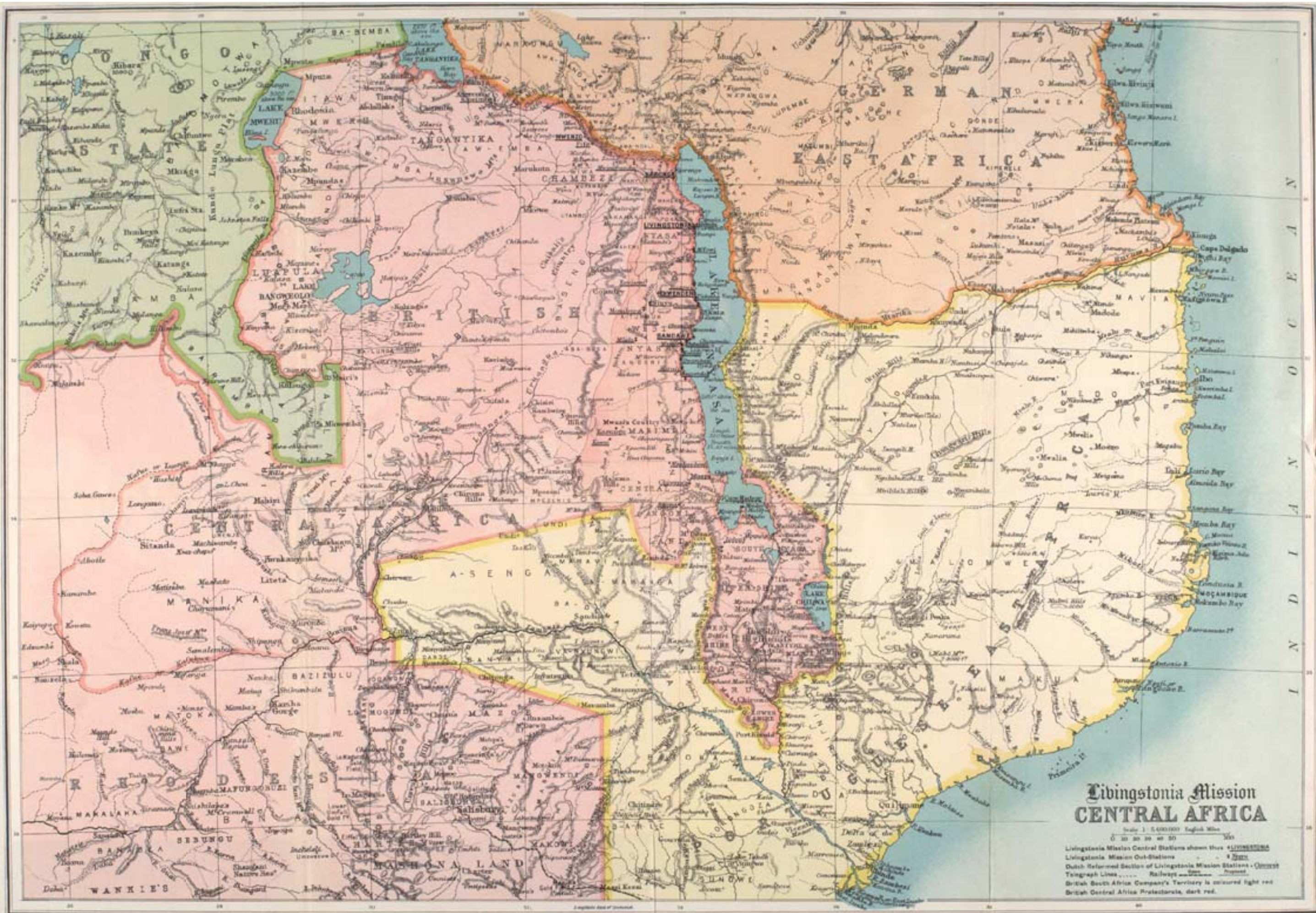
NOTE ON TERMINOLOGY

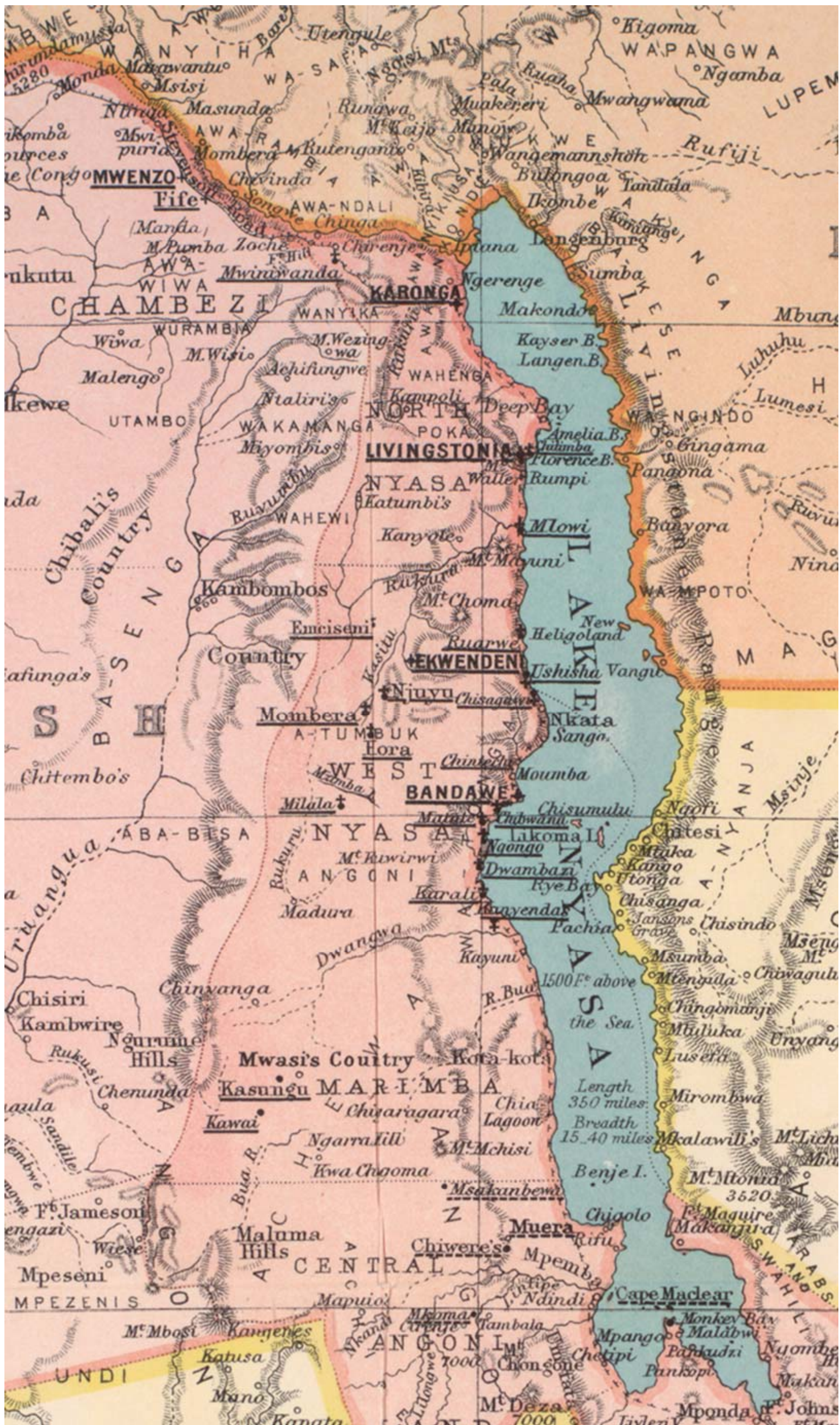
In this thesis, “Northern Malawi region” is used consistently to refer to the area of operations of the Livingstonia Mission, which extended from the present-day Malawi (from 1907 to 1964 Nyasaland Protectorate) to Zambia (Northern Rhodesia from 1911 to 1964) in the west and north-west and Tanzania (German East Africa from the 1880s to 1918 and from 1918 to 1964 Tanganyika) in the north. Both “uTonga” and “Tongaland” are used to refer to the area inhabited by the Tonga on the western shore of Lake Malawi. Similarly, “uNgoni” and “Northern Ngoniland” are both used to refer to the northern kingdom of the Ngoni in Malawi, ruled by the paramount chief M’mbelwa at the time of missionary arrival, which remained independent of British rule until 1904. The term “Livingstonia” has been used to refer to both the Free Church of Scotland mission and its central station, the Overtoun Institution, which was founded in 1894 on the Khondowe plateau. “Free Church of Scotland” has been used to refer to the home church of Livingstonia, which became the United Free Church in 1900 (following the union of the Free Church with the United Presbyterian Church) and in 1929 reunited with the Church of Scotland.

ABBREVIATIONS

ALC = African Lakes Company
AUL = Aberdeen University Library
BCA = British Central Africa
BSAC = British South Africa Company
CCAP = Church of Central Africa Presbyterian
CMS = Church Missionary Society
CSCNWW = Centre for Study for Christianity in Non-Western World
DGMH = David Gordon Memorial Hospital
DRC = Dutch Reformed Church
EMS = Edinburgh Missionary Society
EMMS = Edinburgh Medical Missionary Society
EUL = Edinburgh University Library
FCSMR = ***Free Church of Scotland Monthly Record***
FCS = Free Church of Scotland
FMC = Foreign Missions Committee
GMS = Glasgow Missionary Society
IRM = ***International Review of Missions***
LJEW = Letters of Jane Elizabeth Waterston
LMS = London Missionary Society
LWBCA = ***Life and Work in British Central Africa***
MNA = Malawi National Archives
MoNA= Mombera Native Association
NLS = National Library of Scotland
PIM = Providence Industrial Mission
PMO= Principal Medical Officer
SPG = Society for the Proclamation of Gospel
SSPCK= Scottish Society for Propagating Christian Knowledge
UMCA = Universities' Mission to Central Africa
UPC = United Presbyterian Church
WFM=Women's Foreign Missions Committee
ZIM = Zambezi Industrial Mission



Map 1. Livingstonia Mission in South-Central Africa, 1900. Source: *Annual Report of the Livingstonia Mission of the United Free Church of Scotland for the year 1900*. Reproduced by permission from the National Library of Scotland.



Map 2. Livingstonia Mission in 1900. A detail from Map 1.

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1 INTRODUCTION

1.1 Study of illness, health and medicine: a cultural approach

Concepts of "illness", "disease" and "sickness" all have their particular uses and definitions in the history of medicine. For scholars, the choice between a study of illness and a study of disease is often crucial, differentiating between cultural or social, and medico-scientific or biological, approaches. Ideally, as Megan Vaughan has pointed out, a historian should be able to combine both approaches, but this is the case only rarely.[1]

In Charles Rosenberg's words, scholarly distinctions, "ontological versus physiological, disease versus illness, biological event versus socially negotiated construction – are defensible primarily for analytic purposes."[2] In this study, the primary concern is the experience and understanding of "illness" by historical agents, both individual and collective. In this regard it draws a definition of illness from anthropology of medicine: "Diseases…are never experienced directly; illnesses, cultural constructs of "dis-ease," are what people experience. Illnesses are constructed of belief and knowledge, which vary with both space and time." [3] Conversely, with this cultural approach "health", which has many definitions in social and biomedical sciences, can be simply understood as a socially and culturally constructed and experienced state of wholeness.[4]

This study owes its title to John M. Janzen's influential work on the history and anthropology of medicine in tropical Africa, *The Quest for Therapy in Lower Zaire* (1978). In his foreword to Janzen's study, Charles Leslie provided a theoretical distinction between "medical systems" and "health systems". The study of health systems is concerned with parasites, nutrition, mortality and so forth – an approach primarily based on biology and Western clinical medicine.

---

1 Vaughan 1994a, pp. 286-287.
2 Rosenberg 1992, p. xxiii.
3 Romanucci-Ross et. al. 1991,p. x.
4 Kuhanen 2004, pp. 45-46.

In contrast, medical systems are understood to be social and cultural phenomena. They can include all forms of healing practice, and are generated through the interaction between lay people and specialists, or solely among lay people, "to cure, alleviate or otherwise cope with physical affliction." Medical systems are part of the culture of a society.[5] Whilst this concept of "medical system" has been useful to Africanists, it has also been criticised. Murray Last has argued in favour of the notion of "medical culture" instead of "system". This, according to Last, implies a substance of ideas about medicine and healing without a commitment to the existence of a "total" system.[6] Furthermore, as Vaughan has noted, there are important differences within both "indigenous" and "Western" medical systems, and it is important to study the internal workings of both African and Western forms of prevention and cure.[7]

In this study, the term "medical culture" is preferred to "medical system". Within a medical culture there may be several medical systems, and a variety of relationships between individuals, groups and these systems may be discerned. The field of analysis is a broad pluralistic medical culture involving both Africans and Europeans in the Northern Malawi region in the late 1800s and early 1900s, with a particular focus on the Livingstonia Mission. The study aims to move away from the dichotomous categories of "Western" and "Indigenous" medicine, towards a more sophisticated analysis of "plural medicine". Missionary thought and practice regarding the maintenance of health and curing of disease, for example, extends beyond the narrowly defined field of "Western medicine" as an allopathic system, and is studied in the wider context of colonial culture. Both Western and indigenous medical "systems" and "traditions" are understood to be dynamic and to be socially constructed over time as a result of negotiation, contestation, imagination and innovation.[8]

The actions taken to treat or prevent illness are a major concern of this thesis. In the study of therapy, "healing" and "curing" are key terms. Both terms are problematic, as Vaughan has pointed out, arguing that research in these fields has, to some degree, suffered from the false dichotomy of African

---

5 Leslie in Janzen 1978, pp. xii-xiii.

6 Feierman and Janzen 1992 p. 163, Last 1981; 1992. Janzen defines a system of knowledge as a way of describing the world, and a related, congruent, manner of acting. Janzen 1978, pp. 37-38.

7 Vaughan 1994b, pp. 198-199. The term "indigenous" healing is preferred to "traditional" as the latter tends to imply an unchanging medical system, often associated solely with supernatural causation. See Wallace 2003, p. 355; Feierman 1985, pp. 110-112.

8 Ernst 2002, pp.3, 7-9. Medical pluralism has been succinctly defined by Janzen as "the existence in a single society of differently designed and conceived medical systems." Janzen 1978, p. xviii. Ernst defines "plural medicine" in two ways. The older definition is similar to Janzen's, but in the more complex version, "the term refers to the plural or multi-dimensional qualities inherent in medical practices and experiences, as these draw on and are open to different approaches, are 'bastardised' or hybridised, syncretic, and versatile. Analysis of plural medicine…focus on what could be described as practitioners 'virtuosity' in moving between different doctrines or medical approaches and patients 'versatility' as they draw on a number of different strands of medical practices…" For medicine as contested knowledge, see Cunningham and Andrews 1997.

healing practices and Western medicine. The use of the term "healing" as a category of analysis, which in English "implies a kind of social consensus and a benignness which the observations themselves might lead us to be suspicious of", has been one cause of these problems. However, false dichotomies can also be created by rigidly approaching all Western medical activities in Africa as "curing". Medical missionaries often saw their work in terms of healing rather than curing. Vaughan contends that Africans often regarded medical missionaries as clearly distinct from government medical officers, and that it was missionary medicine that contested African medicine over definitions of the body, disease and health. [9]

This thesis, initially inspired by Vaughan's work, examines Christian mission and medicine through a localised case-study of the Livingstonia Mission of the Free Church of Scotland in Malawi from 1875 to 1930. It adopts a wide-ranging approach to the issues of illness and therapy, including not only Western medical professionals, but also laypeople, and both curative and preventive medical ideas and practices. It could be argued that curative Western medicine forms one medical system and public health another,[10] but this study takes a holistic approach and views both as being interconnected parts. As James Bradley has observed, the practice of nineteenth-century British medicine was divided into three elements: "pathology (the study of disease, including etiology, prognosis, and the actual processes of disease); therapeutics (the cure of disease); and hygiene (the prevention of disease)". An understanding of the interaction of these parts is crucial to the understanding of the whole.[11] When particular attention is paid to the prevention of disease the ideas and actions of laypeople, in addition to specialists, become crucial. This justifies a holistic approach to the study of medicine and healing in the West, in Africa and elsewhere. For this reason, "healing" and "health" are regarded as useful categories within this study. The statements and actions of missionary doctors and lay missionaries and of African patients, practitioners and therapy managers, all have relevance in a study of "healing" and can be approached as part of a common field of analysis.

This thesis, therefore, aims to contribute to the cultural and social history of medicine. However, to concentrate on the social and cultural constructions or frames of illness, health and healing, rather than focus on diseases as biological entities in a historical setting, does not imply the denial of the reality of biological diseases, or validate the argument that only an exclusively social

---

[9] Vaughan 1994a, pp. 294-295.

[10] Feierman and Janzen 1979. Public health has been defined by Charles Hughes as, "all illness that affects the public as well as all activities it undertakes to influence its health status". In her study of pre-colonial public health in East-Central Africa, Gloria Waite has expanded Hughes' definition to include all activities undertaken by ruling elites on behalf of the public for the maintenance of health. Thus, public health is the "meeting ground between politics and medicine." Waite 1992, p. 213 and quoting Hughes 1963, p. 157 in ibid. For the general trends in Anglo-American historiography towards broad approaches to health, healing and sickness, see Leavitt 1990, pp. 1471-1484; Porter 1995; 2002.

[11] Bradley 2002, pp. 27-28.

constructionist approach is epistemologically valid or that diseases are "mere" social constructs.[12] If a historian is to understand, for example, something of the ideas, practices and interaction among the missionaries and African societies relating to smallpox, it must be assumed that a disease called "smallpox" in English and something else in vernacular languages existed, though it could and would mean different things to different people.

When a combined cultural and biological approach is adopted in studies of health and healing the problem of efficacy can often take precedence. The focus of the study can become whether those therapies studied are effective or not.[13] The aim of this study is not to estimate the "real" efficacy of missionary or African therapeutics. It is not concerned with retrospective rediagnosis, but rather concentrates on the ideas, actions and social processes involved in the construction of illness, health, medicine and healing. However, attention should be paid to the perceived efficacy of therapies: what results people expected and experienced, and how they evaluated them.[14] The concept of experience offers one promising theoretical starting point for scholars of the history and anthropology of medicine with an interest in bodily as well as social and cultural aspects of illness and health. Arthur Kleinman has defined experience as "the intersubjective medium of social transactions in local moral worlds. It is the outcome of cultural categories and social structures with the psychophysiological processes such that a mediating world is constituted."[15]

"Medicines" (substances used in the treatment of illness) in this study are understood through pharmaceutical anthropology, as material entities with culturally defined meanings and different contexts – "cultural meanings and social relations within which medicines exist in a given place and time". Whyte and van der Geest have argued that medicines have two distinct qualities. Firstly, they are material substances (and as such can become objects of exchange). Secondly, "they are believed to contain in themselves a power to transform the human condition" from sickness to health: "In medicines, therapy is reified; a *thing,* a healing token is passed from one person to another and applied directly to suffering body. The substance itself is perceived as efficacious, allowing therapy to be separated from the skill and knowledge of the therapist." As "things" they can be thought of as having a "biography": production, distribution, marketing, interpretation and use. Many cultures share the idea that a medical substance has innate healing power, and this basic assumption enables the diffusion of medicines between cultures. However, beyond this common ground of the power of the drug there can be various cultural interpretations about the specific nature of that power. The use of medicines does not require a therapeutic relationship between healer and

---

12 See, for example, Butchart 1998; Cf. Aronowitz 1998, p. 14.

13 Romanucci-Ross et. al. 1991, p. xi. On the difficulties of assessing efficacy, see Lewis 1993, pp. 189-218.

14 See Whyte and van der Geest 1988, p. 7. Harley has argued that, "retrospective rediagnosis is deeply misleading not only because it relies on naïve acts of translation but also because it privileges supposedly stable modern categories." Harley 1999, p. 419.

15 Kleinman 1995, p. 97, quoted in Opp 2000, p. 12.

patient, although a given medicine may be valued because it is provided or recommended by a medical authority. In contrast, other forms of therapy such as surgery or exorcism are the domain of specialists, or are created and arranged by the sufferer or his family. Contextualising medicines requires "placing them together with relevant ideas, historical processes and social relations."[16]

Social constructionism and cultural history of medicine

According to Ludmilla Jordanova, attention to ideas in medicine, together with emphasis on social processes, constitute what should be called a cultural history of medicine. This study belongs to the social constructionist tradition as presented by Jordanova, in that it subscribes fully to a broad approach to medical thinking and "conceptualizing the relationships between such thinking and the setting in which it occurs." Medical thought and practice is understood in terms of mentalities, modes of thought and medical culture.[17] In this respect, the cultural history of medicine approaches cultural anthropology. In the study of African ideas of illness and healing, for example, it has been stressed that medical thinking must be seen within wider contexts and patterns of thought, not as a strictly separate sphere of "medical thought". Ideas about illness and healing, for example, are part of an intellectual whole focusing on the body, the person, the earth and systems of equilibrium.[18]

This study follows Jordanova's advice and utilises social constructionism as a heuristic device for historical practice. In the study of healers and patients, for example, emphasis is placed upon interests: professional advancement, religious affiliation, political allegiance, the quest for power, money and authority, patronage and networks. The concept of "interests" implies "conflict and competition between groups or ideologies." In drawing attention to agency the study of interests offers a counterpoint to all-encompassing theoretical approaches, but studying interests has its own pitfalls. Jordanova warns against mechanistic explanations, such as overemphasis placed upon an individual's religious interests over any medical or philanthropical motives.[19]

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16 Whyte and van der Geest 1988, pp. 3-5, 9.

17 Jordanova 1995, pp. 361-368; The terms "social constructionism" or "construction" have a variety of meanings for different scholars. Rosenberg has criticised the term "social construction of disease" as tautological, a restatement of the "truism that men and women construct themselves culturally". In writing the history of explanatory and classificatory schemes of particular diseases, Rosenberg prefers the metaphor of "frame" instead of "construct", which he regards as more functionalist and programmatically charged. Jordanova, in turn, has argued for the kind of social constructionist approach that is not about "medicalization", does not ignore the material dimensions of life and is not allied with "externalism" in the internalist–externalist dualism within the history of science and medicine. With such caveats, her position can be regarded as being very close to that of Rosenberg, and the conflict between the terms "construction" versus "framing" can be seen as primarily a matter of style. Rosenberg 1992, pp. xiv-xv. See also Aronowitz 1998, pp. 1-15.

18 Jacobson-Widding 1989, pp. 15-16.

19 Jordanova 1995, pp. 365-366, 370-371.

Ideas at the heart of medical endeavour are central to this study. Particular emphasis is placed upon theories, assumptions and representations relating to illness, health and medicine. However, as Jordanova points out, culture is more than only ideas, and a cultural history of medicine needs to be able to analyse ideas and social processes together. For its part, this study aims to contribute to "a historiography capable of explaining the imaginative reach of health, healing and sickness."[20] With such an approach, at a local level, all participants in a medical culture deserve attention, although of course the sources available limit a historian's choices and focus. The missionary doctors in Livingstonia feature prominently in this study, but whenever possible, the missionary archive has been consulted widely regarding the various understandings of illness, health and medicine among doctors, nurses and medical assistants, patients, therapy managers, churchmen, lay missionaries, old and new African elites, healers, local societies and colonial authorities.

As Heather Bell has noted, defining "Western medicine" can be a complicated affair. In a narrow sense, Western medicine can be regarded as self-defining: medicine is what medical professionals do. Medical knowledge is distinct and effective, based on science and deals with diseases which are natural objects. In reality, as Bell points out, the definition of what is medical or non-medical always involves crucial political and social factors.[21] This thesis shares Bell's concerns over the boundaries of medicine. The term "biomedicine" is particularly problematic for this study, as during the period under review Western medical theory and practice underwent massive changes. Even if this study concentrated only upon doctors, major differences would be evident between the thought and practice of the first medical missionaries, whose practice could hardly be called "biomedical", and the later recruits who had been thoroughly trained in institutions committed to established germ theory.

For historians, ideas of what is healthy and what is unhealthy, the debate about normal and pathological and connections between mind and body in sickness, remain a central field of enquiry. As Roy Porter has noted, such questions "...have prompted disparate answers from sufferers and their physicians, as likewise from regulars or irregulars. And such responses have hinged upon wider, extra-medical doctrines respecting order and harmony, good and evil; and upon deep-seated beliefs about the economy of Nature, the purposes of Providence and the meaning of life, ideas articulated in the West within the frameworks of Classical metaphysics, Christian eschatology, and evolutionary biology."[22] In this universal field, medicine and religion meet.

The critical study of missionary medicine in Africa was pioneered by Terence Ranger, who approached missionary medicine as part of a wider study of religious, intellectual and social history of the colonial period in Africa. He questioned the earlier stereotypes of encounters between missionary and African medicine, and pointed out that there was not only conflict or confusion,

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[20] Ibid., p. 374-375.
[21] Bell 1999, pp. 2-10.
[22] Porter 2002, p. 175.

but also common ground between the two. Ranger argued that, in general, missionary medicine in Africa addressed what were regarded to be "diseases of God" in African medical thought, while it was notably incapable of dealing with "diseases of man" – illnesses caused by witchcraft or moral transgression.[23] It was not until the 1990s, however, that missionary medicine in Africa increasingly received scholarly attention.

Social construction of colonial medicine in Africa

In the 1990s, both Megan Vaughan and Alexander Butchart analysed British medical missionary discourse in Africa during the colonial period using a social constructionist approach inspired by the work of Michel Foucault. Vaughan's work assumed the existence of some material reality that underpinned the medical constructs analysed: apart from analysing the shifting disease categories in colonial medical thought, it was assumed that there were "real" diseases and sick people.[24] In comparison, Butchart's work was entirely social constructionist in a Foucauldian sense, and refused to allow any "real" existence to the phenomena studied outside their construction in language.

For some, social constructionism in the history of medicine is associated primarily with Foucault and his followers. As Jordanova has pointed out, however, Foucault is only one of the thinkers who influence this broad tradition. Furthermore, Foucauldian orientation, and emphasis on discourse analysis, has provided novel insights for historians but also caused a number of philosophical and methodological problems. In particular, Foucault's rather nebulous theoretical concept of discourse and the lack of human agency in his approach have been seriously criticised. In Jordanova's words, "The problems arise when discourse is detached from other historical processes, and when a small number of texts are taken out of their context and made to carry a heavy epistemological load."[25]

Butchart identifies two key phases in the evolution of missionary medicine: 1) The theatre of healing (c. 1840–c. 1920), which Butchart compares with Foucault's account of eighteenth-century public displays of sovereign power in France; and 2) the missionary clinic, in which disciplinary power is exercised through the quiet observation of African bodies.[26] Although the outline and analysis of these two aspects of missionary medicine is based on sound study, the parallel between the sovereign power exercised by the king of France during the *ancien regime* and the power of the healing theatre of Western medical missionaries in Africa, is problematic to say the least.

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23 Good 2004, p. 27; Ranger 1975a, 1975b, 1981, 1982, 1992.
24 Butchart 1998, p. 13; Vaughan 1991, p. 7.
25 Jordanova 1995, pp. 368-369. For a philosophical critique of Foucault's work on history of medicine, see Freundlieb 1994, and in general, Merquior 1991. Other influential thinkers in the cultural history of medicine include Robin Horton and Mary Douglas.
26 Butchart 1998, pp. 74-91.

As Vaughan has pointed out, there appears to be significant differences between the (British) colonial power/knowledge regime that produced and constructed "the African" as a colonial object, and the power/knowledge regimes analysed by Foucault. Echoing Vaughan, Frederick Cooper has argued that "power in colonial societies was more arterial than capillary – concentrating spatially and socially, not very nourishing beyond such domains, and in need of a pump to push it from moment to moment and place." Cooper has called for historians to examine "in specific situations how power is constituted, aggregated, contested, and limited." For his part, Paul Landau has in his study of the Tswana and mission Christianity rejected some elements of the Foucauldian conception of power as too indeterminate. Landau stresses that Foucault-inspired African historians need to exercise due care, "as surely not every society underwent a transformation parallel to that of early modern Europe".[27]

Butchart claims that, "It was only in the 1920s that there began to emerge any accounts of the relationship between Africans and the fixed space of the hospital".[28] In South-Central Africa at least, missionary hospitals and dispensaries were built considerably earlier than this. In South Africa, too, missionaries established more or less fixed spaces for healing during the late nineteenth century. Butchart's attempt to create a certain chronology for the "mutations in the anatomy of power" casts up further problems in the case of missionary medicine. His claim to date "moral sanitation" to the mid-nineteenth century and, furthermore, to argue that during this time a specific change occurs in "the anatomy of power", is highly questionable on the basis of Butchart's evidence (as discussed in Chapter 3). Butchart contends that the regime of moral sanitation which emerged in the 1840s as the first phase of sovereign power, was transformed into a second phase of disciplinary hospital regime in the 1920s and then that this discourse and the African body it had produced, "vanished as abruptly as they had emerged" in the 1970s.[29]

Butchart's analysis of medical missionary discourse is based entirely on *published* accounts, and ignores the immensely important missionary correspondence, journals and reports. These documents described medical actions and observations in far greater detail than in publications, at least in the late nineteenth-century Central African context. Missionary publications were often heavily edited and performed an important propaganda function through their reassurances to the general public about the importance and usefulness of medical missions, as well as encouraging material donations and financial support for the missionary endeavour.

Butchart's insistence upon dating certain "transformations" to certain decades is similar to Foucault's observations in France (the timing of which have been questioned by several historians). Butchart seeks the parallel for the theatre of healing from Foucault's description of the sovereign power of the

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27 Cooper 1994, p. 1533; Landau 1995, p. xxiii; Vaughan 1991, pp. 8-12.

28 Butchart 1998, p. 82.

29 Ibid., pp. 89-90. Cf. Comaroff and Comaroff 1997; Good 2004; Hunt 1999; Landau 1995; Rennick 2003.

king, despite the fact that parallels could be sought in the history of medicine: a certain amount of display and showmanship have been part and parcel of medical enterprise for a long time, for example, in the early nineteenth-century theatres of surgery in Europe.[30] Butchart concludes that it was only in the 1970s that "the mutations in the anatomy of power" made it possible to regard traditional African beliefs about illness as something other than the "evils" portrayed by the missionaries, allowing African healers to be included as part of the socio-medical enterprise. If the "regime of power" Butchart has postulated really set such conditions for missionary discourse, then how can it explain Livingstone's interest and respect for the African healers, whom he regarded to some degree as "colleagues"? As many scholars have shown, interest in indigenous medicine was common among the whites, including missionary doctors, in nineteenth-century Southern Africa, not least because of the shortcomings of the available Western medicine. As discussed in Chapter 8, missionary doctors in Central Africa would sometimes explicitly acknowledge the skill of local healers. What is significant is that most of them did not present such views in the missionary *publications.*[31]

The points above highlight some of the problems which result from adopting a "strict Foucauldian" approach. Nevertheless, Butchart's work provides valuable insights for this study. His observations of the *public* missionary discourse are generally convincing, and his analysis of both the theatre of healing and the mission hospital are stimulating, even if the chronology and framework in which they are positioned can be questioned. The statements by missionaries which claimed that indigenous healers had some useful skills and practices, noted above, were uncommon and were often hidden beneath the dominant discourse which labelled them evils and superstitions.

In comparison, Vaughan's work on colonial medical discourses is less problematic for the approach of this thesis. In a subsequent essay, Vaughan has analysed not only discourses, but also medical practices, and highlighted some of the differences and contradictions between colonial and missionary medical theory and practice. In many respects, this study aims to develop certain key points made about missionary medicine by Vaughan in a detailed case-study dealing with both theory and practice. These include the missionary concern with morality and health, the programmes for public health provision through "social engineering" and the promotion of Christian religious values, as well as tensions between religious and medico-scientific strands in missionary thought. Among the important issues to be considered when examining the medical encounters and exchanges between missionaries and Africans are the roles of African "middles", medical pluralism and competing social definitions of illness.[32]

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30 Porter 1997, pp. 360-374.

31 Comaroff and Comaroff 1997; Etherington 1987; Gordon 2001; Hokkanen 2004; Lalu 1998.

32 Vaughan 1991, pp. 55-75 and *passim.*; Vaughan 1994b. In the study of colonial medical history, Hunt has paid attention to the importance of African "middles" or

Power, hegemony and medicine

Power and power relations, both real and imagined, are central to the study of colonialism. They also feature prominently in the study of medicine in the social sciences. As Maryinez Lyons has pointed out, medical systems and ideologies frequently protect power relations and conservative cultural values: "The maintenance and restoration of health and the prevention of cure are nearly everywhere activities entrusted to specialists who, with their rituals and techniques, command much respect and sometimes fear, and who invariably possess power and authority."[33] The generic association between health and morality in most societies is where medicine, religion and/or magic operate. In this intersection, power relations, ideas, ideologies and values are negotiated in an important way between specialist healers, patients, and society at large.[34]

In this thesis, the Foucauldian regime of power/knowledge has not been taken as one a priori category of analysis. For its part, this study attempts to examine different intentions, contests, arrangements and limitations involving medicine, healing, and power. Foucault's work has had a general influence upon this enquiry, but has not provided a theoretical framework or methodology. Another theorist of power relations in society, Antonio Gramsci, has also inspired a number of studies of colonial power. Gramsci's ideas of hegemony, consent and coercion have appealed in particular to scholars who have found Foucault's model of power lacking in human agency and subjectivity. The great advantage of Gramsci for historians is his introduction of subjectivity into the analysis of subordination and domination, and his understanding of intellectuals as crucial groups in negotiation and contestation over hegemony. Nevertheless, as Engels and Marks have argued, Gramsci's "insights cannot be taken as prescriptive, but as clues which suggest new ways of exploring and interpreting the past".[35]

Raymond Williams defined hegemony as:

> not only the articulate upper level of "ideology", nor are its forms of control only those ordinarily seen as "manipulation" or "indoctrination". It is a whole body of practices and expectations, over the whole of living: our senses and assignments of energy, our shaping perceptions of ourselves and our world. It is a lived system of meanings and values.[36]

"middle figures", a new group of people mediating the medical exchanges through negotiation, translation and action. "Middles" included African medical assistants, nurses or untrained intermediaries. Hunt 1999, pp. 7, 23 and *passim.*

33 Lyons 1994, p. 203. Allan Young has stressed the role of ideological knowledge in medical thought, noting that, "Beliefs about sickness and healing are ideological because they identify locations and forms of power and moral accountability…"Young 1981, p. 384.

34 For similarities between magic, religion and science, see Horton 1993.

35 Engels and Marks 1994, p. 2; Feierman 1990, pp. 17-27. See also Vaughan 1994c. Vaughan notes that the notion of hegemony as presented by the Comaroffs (1991) is similar to Foucauldian notion of discourse in some respects, but hegemony implies some kind of intentionality, and that hegemony is never total.

36 Williams 1977, p. 110, quoted in Arnold 1994, p. 132 and Gaitskell 1994, pp. 110-111.

Hegemony is the part of a dominant ideology that appears to be naturalised and not ideological at all. However, no hegemony is total. It can be regarded as a process that needs to be constantly remade, and can thus be unmade.[37]

The fields of medicine, public health and education are particularly promising for Gramsci-inspired analysis: the results, however, have been mixed. David Arnold has highlighted the duality and ambiguity in Gramsci's thought, and argued that ambiguities and contradictions characterise the history of public health and medicine in colonial India. While the British colonial medical authorities had undeniable hegemonic aspirations, and colonial medicine constituted an influential ideology, in practice, in India, the impact of colonial medical ideas and public health policies remained limited.[38] In turn, Vaughan argues that colonial medical discourse and practice in Africa was alienating rather than integrating. As such, colonial medicine in Nyasaland does not appear to have been a successful case of "hegemonic" rule. However, for Vaughan, a hegemonic function could be seen outside the state, in the education of medical assistants, midwives and nurses, which was mainly executed by missions.[39] As a hypothesis, it may be suggested that medical practice involving missionaries and Africans was not only either alienating or integrating, but was a complex field of interaction with various degrees of communication, contest and co-operation between healers, patients and various intermediaries. In this thesis, the issues of hegemony, consent and coercion are explored particularly with regard to the medical and moral education in the Livingstonia Mission and the emerging Presbyterian Church in the Northern Malawi region.

For all its importance, "power" remains a problematic concept. Both Foucault and Gramsci have proved difficult theorists for historians of colonialism in Africa, providing inspiration and insight but no coherent methodology. When the focus of analysis is upon the historical agents, and their ideas, intentions and actions, it is important to differentiate, in principle, between "imagined" and "actual" power, as difficult as this may be in practice.

Healing, rhetoric and interpretation

David Harley has argued powerfully that historians who "avoid beliefs, intentions and cognition, focusing instead on power, practices and performance" cannot adequately comprehend the role of healing in society.[40] Harley stresses the importance of analysis of social rhetoric and narratives in studies of patients and practitioners:

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37 Comaroff and Comaroff 1992, p. 29, quoting Williams 1977, p. 109.

38 Arnold 1994, pp. 132-140. Significantly, Arnold observes that outside the colonial state, the Christian medical missions in India had more impact on Indian ideas, lifestyles and experiences than colonial medicine, although sometimes the lines between the two became blurred.

39 Vaughan 1994b, p. 191.

40 Harley 1999, p. 408.

> Most patients can answer back or walk away, so persuasion is crucial, not only as a market strategy but for the very process of healing. Patients or their relations come to the healer with their stories, however fragmentary. Out of this story, and other elements, the healer fashions a new story. This narrative interaction is neither merely fictional nor merely mimetic. The therapeutic process is constructed as narrative in time, incorporating change, order and meaning...[41]

For Harley, rhetorical analysis is a method of connecting disparate studies in the history of medicine, and argues that "the nexus of the field should be health and healing, which are rhetorical constructs created in particular social locations." In Harley's scheme, rhetorical analysis offers generic tools for scholars:

> Placing plausibility, the quest for meaning, and their material effects at the centre of the attention facilitates the task of treating symmetrically learned and unlearned practitioners, past and present medicine, biomedicine, and traditional or religious healing. For exorcist and possessed, or midwife and mother-to-be, or physician and patient, the relationship is created by semiotic, ritual and discursive acts, which are effective only in relation to specific cultural-symbolic and social-structural circumstances…Since medical knowledge is intended for therapeutic or prophylactic use, at least in principle, its creation and deployment can be seen in similar rhetorical terms to those appropriate for the analysis of any aspect of healing anywhere.[42]

A historian working with sources written by healers therefore analyses and reconstructs historical healer-patient relationships, interactions and exchanges from the stories fashioned by the healers, and in the process fashions a new (hi)story. In such a situation care and awareness is required in any attempts to interpret the thought and action of patients even when the doctors and patients share the same culture and language. Particularly relevant to this study is F.B. Smith's comparison of the study of nineteenth-century British patients using sources written by doctors with the study of African history from colonial sources.[43] The situation becomes increasingly complicated when European sources describe the interaction between European doctors and African patients in the early colonial period. The crucial question then becomes, what can be said of the experiences of African patients?

Vaughan has argued that for scholars interested in the social and cultural construction of disease, a crucial question to ask an African patient in a Western medical setting would not be does she believe in the leprosy bacillus but does she believe in leprosy as a definition. The issue is "of competing social definitions of disease and illness, not of scientific versus pre-scientific modes of thought". Mission medicine was in many respects different from colonial medicine, and this difference was recognised by some African communities. However, others did not differentiate between types of Western medicine in such a way.[44]

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41 Ibid., p. 422.
42 Ibid., pp. 432- 433.
43 Smith 1979, p. 10.
44 Vaughan 1994b, p. 199-200.

Medical pluralism

The subsequent emergence of a new medical pluralism, or plural medicine, in which indigenous medicine persisted after the introduction of Western medicine by the colonizers, remains one of the most important topics for historians and anthropologists of medicine and healing in Africa. Vaughan has argued that the emergence of medical pluralism provides good grounds for turning "imperial hegemony" on its head. Indigenous medical systems seem to be able to pursue successful hegemonic strategies and can appropriate and reinterpret symbols of colonial power for their own ends. In this perspective, diviners, herbalists and "traditional" midwives constitute a medical orthodoxy and the colonial medical practitioners are the equivalents of quacks in Europe.[45] This is a useful perspective to reflect upon. While the missionaries understandably appear as the central figures of their own narratives and the hospitals and dispensaries, as centres of healing, when placed within the perspective of the nineteenth- and twentieth-century history of South-Central Africa, they were very much "marginal men" and women.[46] In a study such as this, it is vital to also recognise and acknowledge what is not included in the research. The quests and contests for healing examined here largely on the basis of the missionary archive are a mere fraction of the medical culture of the late nineteenth- and early twentieth-century Malawi region as a whole.

Since the early 1990s, a number of studies have discussed missionaries and medicine in Africa during the colonial period. In important and inspiring works by Jean and John Comaroff, Paul Landau, and Luise White, missionary medicine has been discussed as one theme among many in the study of Christianity and colonialism in Southern and East-Central Africa.[47] By comparison, Nancy Rose Hunt, in a major study, has brought interactions in the colonial situation of missionary medicine to the fore in novel ways. Crucially, Hunt has confronted the difficult issue of African "readings" of missionary medical ideas and interventions by focusing on the African nurses and "middles" of medical practice. Most recently, Charles Good has written an extensive study of historical-medical geography about the medical agenda of the Universities' Mission to the Central Africa (UMCA) in the Lake Malawi region.[48] Good's interdisciplinary approach, which focuses on steamer technology as well as missionary medicine, has some common elements with this study, notably the emphasis placed upon medical pluralism. However, Good's work is concerned with both health and medical systems, with ecological, biological as well as cultural aspects of health and disease, and is mostly preoccupied with twentieth-century missionary biomedicine.[49]

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45 Vaughan 1994b, pp. 196-198.

46 Cf. McCracken 1989.

47 Comaroff and Comaroff 1997; Landau 1994; White 2000. For German medical missions during colonial period, see Eckart 1997.

48 Good 2004; Hunt 1999, pp. 159-161 and *passim.*

49 Good 2004, Chapter 6 and *passim.* Good attempts to assess the "impact" and efficacy of missionary medicine, and for this purpose he constructs a historical "baseline" of precolonial health in the Malawi region. His work is crucially based on missionary

1.2 Limitations and definitions: the study in time, place and theory

In the study of the colonial history of Africa, a cultural historian of medicine needs to take into account a number of factors peculiar to African and colonial history, some of which place severe restraints upon or raise difficulties with the approaches suggested by Jordanova and Harley. As Jordanova points out, medical interactions only become fully understandable if the verbal and visual languages that mediate them are deconstructed. This is feasible when there are shared languages of health and sickness, and fairly clearly defined conditions.[50]

In this respect, the colonial situation seems to be drastically different from most European societies. To begin with, European missionaries and Malawians did not have a clear, shared verbal language of health, illness and medicine. The roles of African intermediaries and interpreters were crucial in the history of the mission. However, these important individuals often left few direct records in the archives. The importance of visual language is apparent, but its reconstruction and analysis is severely hampered by a lack of available source material. However, as medical practice is visual at heart, attention should be paid, where possible, to what missionary medical practice, its medicines, instruments and techniques, looked like. In Hunt's words, "colonial medical performances were media that communicated ideas, images, and gestures, and remade old metaphors".[51] It must be recognised, however, that a study based on written primary sources cannot comprehensively reconstruct colonial medical dialogues. Such a task would require extensive use of oral history as well as thorough analysis of colonial vocabularies, as Hunt has demonstrated.[52]

If this study faces serious limitations due to its emphasis on written records when studying exchanges between the missionaries and Africans, there are greater possibilities to study the thought and practices that aimed to cure or preserve the health of missionaries themselves, and the role of health and healing in the emerging Christian church and society. As Eric Jennings has pointed out, studies of colonial medicine have rarely concentrated in detail on mainstream medical and "parallel" medical practices applied to the colonizers, and their significance for wider colonial cultural history.[53]

This thesis has a local emphasis. However, the localities concerned are dispersed, including both South-Central African areas where Africans and missionaries met, and the Scottish and British settings in which the missionaries formerly lived and trained and to which they remained closely connected. Local

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publications supplemented by oral sources and secondary sources, and largely covers a different region and time period. Although he refers to Mudimbe's work, he does not address the problems of missionary language discussed below.

50 Jordanova 1995, p. 376.

51 Hunt 1999, p. 185; Jordanova 1995, pp. 375-376; McCracken 2000; Thompson 1995; 2000.

52 Hunt 1999, p. 23 and *passim.*

53 Jennings 2002, p. 230.

approaches allow a cultural historian of medicine to pay close attention to practitioners and patients as well as the interaction of medicine with agencies such as the law and the church.[54] In this thesis, the relationship between medicine and the mission, African authorities, colonial rule and the churches come under particular scrutiny, and are examined at individual, structural and ideological levels.

On colonialism and colonial encounters

The terms "colonial" and "colonialism" require definition, particularly because they, together with "imperialism", are often laden with strong connotations, not least in the study of the history of Christian missions in Africa. Questions such as whether missionaries were imperialists or not, and the nature of the relationships between various missions and colonial/imperial administrations, have been the subject of somewhat intense debate for a number of past decades. The works of Brian Stanley and Jean and John Comaroff are particularly noteworthy studies of missionaries and imperialism, although they differ greatly in approach. Criticising these studies for what he regards to be their representation of missionaries as simply cultural imperialists, Andrew Porter has called for detailed ground studies. Porter stresses the need for distinctions to be made between missionary presence, missionary influence and missionary imperialism. He draws attention to the attractiveness of Christian beliefs, for example in the experience of evil in the shape of poverty and disease.[55]

The major debate about how far missionaries can be viewed as imperialists is largely beyond the scope of this thesis, but it is necessary to discuss the issue further. The study aims to contribute to this debate as one ground study of the type Porter demands, and address the connections between illness, medicine, colonialism and the emergence of an African church under the auspices of Livingstonia. Porter's point about Christianity and health must be compared here with the arguments about the relationships between medicine and conversion in Africa. According to Robin Horton, missions in Africa significantly failed to adequately address the health and healing requirements of local communities, a failure which contributed significantly to the establishment of independent African Christian Churches and spiritual movements in which healing occupied a central position. Ranger has commented upon the inability of missionary medicine to deal adequately with "the diseases of Man", caused by witchcraft and moral transgression. However, Bengt Sundkler asserted in the late 1940s that at least one-third of first-generation converts in South Africa where he worked had embraced Christianity following experiences of illness and healing, and many through the influence of the mission hospital.[56] In this thesis, the complex relationships

[54] Jordanova 1995, p. 374.
[55] Comaroff and Comaroff 1991; 1997; Porter, A. 1997; Stanley 1990.
[56] Horton 1993; Ranger 1981, 1982; Sundkler 1948.

between healing and religious conversion in Livingstonia have not been taken as a separate topic of research, but are discussed as part of a holistic cultural historical study. The emergence of the African Church and Christian communities in Northern Malawi are major social historical processes which are discussed together with ideas and practices about health and healing, but the specific process of conversion, as will be noted, is very difficult to address in this work.

In this study, as a starting point, "colonial" is understood, following Bronwen Douglas, as a "general epithet denoting European attitudes and intentions towards indigenous people, and the texts that Europeans and their affiliates produced about them, from first contacts until decolonization." Douglas has argued that "colonial" does not need to imply formal colonial control or homogeneity in the "colonial project". Furthermore, Douglas stresses that the colonial intentions to "possess" others, " – formally and informally, symbolically, intellectually, economically, spiritually or politically – were variously and ambiguously realized, if at all."[57] Therefore, for example, individual missionaries could have "colonial" ideas and intentions, while not being part of a formal colonial occupation or having an explicit colonial ideology. The use of the term should not imply any sweeping generalisations or moral judgements. It is argued that for this study such a broad definition and approach is necessary, and to Douglas' list of attitudes, intentions and texts must be added historical events, actions, material elements and contexts.

It is important to reiterate the heterogeneity of colonialism or colonial intentions, ideas and activities. In the study of colonialism, theoretical and conceptual definitions have proved complex and problematic. In their seminal study of colonial evangelism in South Africa, John and Jean Comaroff have discussed the issues involved at length. They have chosen not to construct a single "theory of colonialism", but have put forth key propositions about colonialism, outlining a theoretical orientation for its study.[58]

The Comaroffs emphasise that colonialism was a process in political economy and culture simultaneously and inseparably. They argue that studying the cultural, political, and economic aspects of colonialism entirely separately prevents scholars from seeing their ontological unity. For example, in studies exploring colonialism as "cultural formation", "discursive formation" or as a "regime of power/knowledge", the material aspects of colonialism have often been entirely ignored. The Comaroffs stress the role of unofficial agents of the colonial process, such as missionaries, traders and settlers, who influence the life of "native" populations.

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57 Douglas 2001, p. 55, endnote 3. In the historiography of the British Empire, "colonial rule" has traditionally meant rule by local colonialists or companies for example in early Rhodesia, while Protectorates such as the British Central Africa Protectorate, were subject to "imperial rule" from London. In this thesis, "colonial" is used throughout to refer to all aspects of British administration in the region, as well as the ideas of and activities by missionaries and secular settlers.

58 Comaroff and Comaroff 1997, p. 19.

Colonialism not only created colonial subjects and defined areas as peripheries and colonies but was also concerned with the creation and definition of the metropolis and the formation of the identities and ideologies of the colonizers. Identities were formed and contested in colonial locales, and these new identities would ultimately be taken back to the home country. The categories "colonizer" and "colonized" rarely, "represented an undifferentiated sociological or political reality." However, despite the complexities of colonial societies, they have repeatedly been seen and represented from within in strong dualistic terms. The aim has been to clearly differentiate between the rulers and the ruled, black and white, modern and traditional, law and custom, European and non-European, and so forth. Naming and ordering difference was essential to colonialism, and this often became part of the world of the colonized, in their identities and self-construction. The non-Western societies involved in the colonial process were not "closed", "traditional", or unchanging. Rather, they were "complex, fluid social worlds, caught up in their own intricate dynamics and internal dialectics, the working of which had a direct effect on the terms of the colonial encounter." Colonialism was essentially marked by discontinuities and contradictions, fruitful starting points for critical scholarship.[59]

The Comaroffs' central proposition is that colonial encounters consisted of a complex "dialectic" that changed everything and everyone involved, but in differing ways. This process, which incorporated material, social, and cultural elements, produced new identities, frontiers, signs, styles and meanings.[60] This attention to both the material and non-material aspects of colonial history reinforces the holistic approach to the cultural history of medicine that is central to this thesis. As Whyte and van der Geest have noted, in situations of pharmaceutical pluralism, terms like "indigenous" and "Western" are almost unavoidable, but they must be used with care, as the pluralistic context transforms both imported and native medicines.[61]

Hunt has criticised the use of the term "colonial encounter" in colonial historiography. It is often used to describe a single "encounter",[62] which frequently turned into an account of how Europeans "impacted" upon the indigenous people. In such narratives, indigenous people are often assigned a passive role, limited to reaction to European action. In the study of colonial medicine, as Worboys has indicated, it can be argued that indigenous healers and patients were proactive as well as reactive, that "adoption of Western medicine was usually selective and synthetic" and that many groups remained largely unaffected by it.[63]

In practice, scholars have to make decisive choices of perspective and emphasis regarding "colonizers" and "colonized" as objects of study, depending on their interests and the resources available. For example, there has been a traditional division between African history and imperial history in the

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59 Ibid., pp. 19-28.
60 Ibid., pp. 28-29.
61 Whyte and van der Geest 1988, pp. 10-11.
62 Hunt 1999, p. 160.
63 Hunt 1999, p. 160; Worboys 2000b, pp. 209-210.

English-speaking world. At the macro-level, in the field of "overseas history", as Henk Wesseling has argued, two distinct and different forms of history can be discerned: the autonomous history of Asia and Africa, and the history of European expansion. But this is not enough. Some, but by no means all, of European, African or Asian history can be understood as autonomous history, but for in the remaining history the "others" absolutely need to be taken into account.[64] In a micro-level study such as this thesis, the research must incorporate both Africans and Europeans in particular historical situations and settings.

The Comaroffs have highlighted the mutually beneficial connections between cultural history and historical ethnography. Critical cultural history can analyse how "culture" is often a result of contests and arguments, and from "fragments, discord and even from silences" it is possible to recover valuable material for historians and social scientists. Bernard Cohn has argued that for anthropological history, as well as for historical anthropology, the "colonial situation" should "not to be viewed as 'impact', nor as 'culture contact', nor is it to be viewed through a methodology that seeks to sort what is introduced from what is indigenous. It is rather to be viewed as a situation in which the European colonialist and the indigene are united in one analytic field."[65] A comprehensive study of a colonial situation would take a balanced account of both the "colonizer" and the "colonized".

An emphasis on limited locality is a requirement of such an approach. As Nicholas Thomas has argued, "only localized theories and historically specific accounts can provide much insight into the varied articulations of colonizing and counter-colonial representations and practices…colonialism can only be traced through its plural and particularized expressions…"[66] This does not mean imposing narrow limits on the relevance of the study. Terence Ranger and Eric Hobsbawm, among others, have defended the study of local historical processes through thick description, and its significance to world history. As Hunt has convincingly shown, a microhistory of the colonial medical exchanges surrounding one mission station can be seen in local, metropolitan, colonial and denominational frames.[67] In this thesis, this is attempted in the case of the Livingstonia Mission in Northern Malawi.

The study in place and time

If the colonial period in Malawi was defined by the establishment of formal colonial rule, it would begin in 1891 with the establishment of a British Protectorate. For this study, however, the starting point is the establishment of the first permanent European settlement in Malawi, the Livingstonia Mission, in October 1875. From this time onwards, there was a continual presence of

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64 Wesseling 1991, pp. 87-88.
65 Comaroff and Comaroff 1992, p. 18; Cohn 1998, p. 44.
66 Thomas 1994, pp. ix, x.; quoted in Hall 2000, p.16.
67 Hunt 1999, p. 6; Lonsdale 2000, p. 9.

Scottish missionary doctors in the region, and an ongoing process of contacts involving medicine and healing between the missionaries and Malawians.

Livingstonia Mission, which, in addition to its base in Malawi, at its largest included sizable areas of present-day Zambia and Tanzania in its sphere of operations, was arguably the most important mission in the region at least until the First World War. During its heyday, it was one of the most well-known missions in Africa, an example to others especially in its educational policy and, according to Oliver, perhaps the only truly successful residential mission in East and Central Africa during the late nineteenth and early twentieth centuries.[68] Medicine and the medical professions featured prominently within the mission from its inception. It was founded in 1875 by James Stewart in memory of the best-known Scottish missionary doctor, and was run from 1877 to 1927 by Robert Laws: both men were missionary doctors themselves.[69] The mission boasted a remarkably high proportion of medical professionals, especially doctors, among its staff during this period. In consequence, the Livingstonia archives contain voluminous correspondence between doctors. This correspondence enables detailed study of medical missionary thought and practice between 1875 and 1930, a period that has not been studied adequately in previous research on medical missions in Africa.[70]

Livingstonia mission and its social, political, economic and intellectual influence in Northern Malawi has been analysed by John McCracken in his classic study, *Politics and Christianity in Malawi, 1875–1940* (1977, 2nd ed. 2000). This comprehensive work synthesises the social and political history of the mission and has been an indispensable starting point for this study. McCracken noted the need for further studies into the medical practice of Scottish missionaries. One such pioneering study of the Malawi region is Agnes Rennick's doctoral thesis (2003), which compares missionary medicine at the UMCA, Blantyre and Livingstonia missions before the First World War. Her work concentrates on missionary doctors, nurses, patients and hospitals, and analyses the roles of the medical mission personnel, the practice in hospitals and attitudes towards disease. Rennick's valuable work is limited to medical professionals and patients, and belongs to the tradition of social history of

68 Oliver 1952, p. 65.

69 Rev. Dr Robert Laws (1851–1934) was born in Aberdeen and educated at Free East Church School, Aberdeen University, UP Church College, Glasgow University, and Anderson College. He obtained degrees in Arts, Theology and Medicine, and graduated as MD in 1877, following two years of practice in Livingstonia. He was ordained in 1875 and was the Moderator of the United Free Church of Scotland 1908–1909. Livingstone 1921; McIntosh 1993.

70 Vaughan, Hunt, Good and White have all concentrated on twentieth-century missionary medicine, while the Comaroffs' work has focused largely on the early and mid-nineteenth century. Late Victorian and Edwardian missionary medical practice, in particular, has not been thoroughly studied. The selection of 1930 as the end date of this study is to some extent artificial: the departure of Laws from Livingstonia in 1927 and the change of Livingstonia to a Church of Scotland mission in 1929 mark a watershed in the history of the mission, but the study of quests for health among African Christians in Chapter 11 requires discussion of some events from the early 1930s.

medicine.[71] In contrast, this study aims to provide a cultural historical analysis, exploring not only medicine, practitioners and patients, but also ideas, practices and social processes relating to health and illness, which involved practitioners, influential laymen, and African patients, healers and therapy managers. It examines the influence of ideas about health and illness not only within the mission hospital, but also in church, school, and housing, for example.[72] This wider and deeper approach requires a narrower geographical focus. For this reason, the study concentrates exclusively on one mission with an extensive archive. This enables wide-ranging consultation of missionary and colonial sources, African church records, writings and oral sources, together with anthropological studies.

1.3 On sources and missionary language

This thesis is based on written primary sources, the vast majority of which were produced by the Scottish missionaries and their associates in Livingstonia, collectively called "the missionary archive". The resources for this study allowed only a short period of field research in Northern Malawi, with nine selected interviews. Those interviewed, with the exception of the oldest interviewees, provided access to traditions rather than testimonials. As the majority of informants were born in the 1920s and 1930s, they had little direct contact with or personal memories of early missionary medicine. However, they were familiar with the traditions of the Presbyterian Church in Northern Malawi, and provided particularly valuable accounts of the early African Church and its leaders, their interaction with the missionaries as well as African and Western medicine in the local communities.[73]

The limitations of the oral sources prevented the themes of medicine and healing being approached in such novel ways as White and Hunt in particular have done.[74] No African medical assistants, nurses or former patients who worked or were treated at Livingstonia during the period studied could be found. The traditions of those outside the Christian community, in particular African healers, were not consulted. As resources did not allow the extension of the period of the study to the 1940s and the 1950s, this thesis remains based on written sources, supplemented by oral sources. This poses particular problems for historical source criticism, especially concerning the missionary texts which are crucial to this work.

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71 McCracken 1973; Rennick 2003.

72 The holistic approach to history of therapeutics and health in Africa has been pioneered by Steven Feierman, see Feierman 1985.

73 Three of the informants (L.H.T., M.M.D.S and W.C.) were descendants of early prominent Livingstonia church leaders. The four oldest informants, who were born in 1907, 1916 and 1920, lived their youth and childhood during the period under study.

74 Hunt 1999, White 2000.

The philosopher V.Y. Mudimbe has argued, in his thought-provoking analysis of missionary language, that missionary speech can be regarded as being always predetermined and pre-regulated within the framework that Mudimbe calls "the authority of truth". This, Mudimbe holds, is based on the missionaries' belief in God's will for "the conversion of the world in terms of cultural and socio-political regeneration, economic progress and spiritual salvation". Mudimbe insists that within this framework, missionaries could not enter into real, equal dialogue with pagans and "savages", but had to impose the law of God upon them and their societies. In the colonial context, missionaries served as envoys of God, representatives of civilization, and agents of empire without essential contradictions. Mudimbe argues that all these roles had the same purpose: the conversion of African minds and space. Mudimbe presents a general ideological model of conversion during the colonial rule:

	Premises	**Mediators**	**Aims**
Status	Primitiveness	Conversion	Civilization
Symbols or signs	Pagan (evil) Naked (child) Cannibal (beast)	Christianity Education Evolution	Christian (good) Civilized (adults) "Evolué" (human being)
Method	Anthropological presuppositions	Missiology Applied anthropology Pedagogy	Colonial sciences

Mudimbe argues that missionary language is a cultural position, the expression of an ethnocentric outlook. The language used depends on three major types of data given and taken for granted: premises, mediators and objectives. All of these tend to integrate religious and cultural aims. An evolutionary thesis expresses the conversion from savagery and darkness to God's kingdom and the light of civilization. Thus, Mudimbe formulates the missionary theology of salvation: [75]

	Premises	**Mediators**	**Aims**
Status	Primitiveness	Conversion	Western Civilization Christianity
Symbols	Illness	to introduce to restore	Health
	Disorder	to establish	Order
	Darkness	to promote	The Light of God and Civilization
Method	Derision	Demonstration	Conformity

75 Mudimbe 1988, pp. 47-54. Within this framework, however, Mudimbe identifies certain variations. Some missionaries concentrated on mediators and aims rather than premises.

In Mudimbe's model, the centrality of health and illness to missionary thought and language is clear. "Illness", together with "disorder" and "darkness", are powerful symbols of Africa and Africans before missionary intervention, which aimed to introduce or restore "health", "order" and "light". The method for achieving this followed the model derision–demonstration–conformity, in evangelisation, education and medical practice.

Not surprisingly, the missionaries' language and knowledge of Africa and Africans has often been criticised in the West, particularly by anthropologists, since the early twentieth century. Mudimbe points out, however, that many critics have tended to overlook the fact that missionaries often spent far more time than most anthropologists, sometimes their entire lives, in Africa, sharing their everyday life with Africans and acquiring a remarkable fluency in the vernacular languages. Mudimbe argues that in such cases, missionaries' existential understanding of local habits and customs was often extraordinary. The difference between missionaries' and anthropologists' interpretations stems from the intellectual particularity of their respective objectives.[76] In theory, then, Mudimbe seems to allow that missionaries can be, to some degree, reliable witnesses of historical events in an African community, although their statements must be considered in the context of their mission and the framework of missionary language. Mudimbe's theoretical model of missionary language is tested and criticised on the basis of historical assessment of the missionary sources under scrutiny.

The missionary archive

Missionary sources consist of private and official correspondence, published and unpublished letters, journal articles, reminiscences, reports, diary and journal entries, photographs, drawings and objects. For a historian, all of these sources have to be closely evaluated according to the conditions of their origin with a view to their possible value as historical evidence.

Recent studies of the missionary archive have stressed the importance of the dialogues that careful examination of the missionary material often reveals. Dialogues between the missions and their domestic societies, between Western and indigenous religious beliefs, and between different social and cultural practices can all be found in the missionary archives. Arnold and Bickers have stressed that special skills are required when consulting these archives. Uncritical reading of mission sources can often lead to serious misunderstanding and an evangelical bias, while secular study of missionary writings is difficult if the reader does not have the necessary patience. In the study of indigenous societies, mission archives can be called a "tainted" source. Missionary texts are usually written in different languages from those societies

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[76] Mudimbe 1988, 65-66. The value of some missionary ethnography and understanding of local knowledge has also been acknowledged by many anthropologists. See, for example, Pickering 1992, p. 101.

that they refer to. This causes significant difficulties for example in the identification of individuals from missionary transliterations of their names. However, recognising an evangelical bias in the missionary sources, and adopting an anthropological approach to the missionary archive can prove fruitful, as J.D.Y. Peel has argued.[77]

This thesis is based on the notion that the missionary archive can be consulted with care when studying indigenous societies without insurmountable problems arising from its biases. Together with Mudimbe's insistence on the importance of missionary language, this is a crucial premise for this study. However, the extent of missionary knowledge and understanding of local societies is often difficult to assess. As Adrian Hastings has pointed out, the Victorian missionaries' working knowledge of a local language was a crucial factor in their understanding of local culture, and it is often difficult to assess whether the missionaries were actually fluent in a language. While some became capable linguists, others never learned to converse seriously in the vernacular.[78] Even for those who spoke only English, some inter-cultural communication took place, though exclusively through African mediators and interpreters.

The study of missionary thought, an important aspect of this research, is less philosophically and methodologically problematic. However, careful textual analysis and close reading are still essential. In the study of attitudes, ideas and personal experiences, private, unedited correspondence and diaries are often regarded to be most valuable form of historical testimony. In the case of Livingstonia missionaries, a large part of their surviving correspondence was sent from the missionaries in the field to the secretaries of the Foreign Missions Committee at home. A large collection of letters from fellow missionaries to Robert Laws has survived. Furthermore, the voluminous correspondence of Laws is available in the National Archives of Malawi for the period 1894–1927, although some of these letters are now in an unreadable condition. The unedited and often confidential letters between missionary doctors have been particularly valuable. The National Archives of Malawi also hold a collection of Laws' sermons from 1883 and his patient book for 1880–92. A private journal of Dr William Scott, a medical missionary at Bandawe station between 1883 and 1886 is a valuable addition to the official material. Another important unofficial source has been the collection of Dr Jane Waterston's letters (1879–80), the first woman doctor at the Livingstonia Mission. For the later period, the published correspondence of Jack and Mamie Martin, missionaries at Bandawe (1922–28) has also been particularly valuable.

In addition, there remain edited versions of missionary letters sent home that were published in missionary periodicals. These letters were edited and published with a specific propagandistic purpose in mind, namely to report back to the church-going public who funded foreign mission work, charting progress and deliberately pointing out all obstacles to missionary work that,

77 Arnold and Bickers 1996, pp. 1-3; Peel 1996.
78 Hastings 1994, p. 303.

mission propagandists believed, could be overcome by an increase both in funding and in numbers of recruits. These letters were often double-edited: first letters were self-edited by missionaries in the field, and then later scrutinised by the editor of the missionary journal. Although some missionaries may have been frustrated by editorial interference and manipulation, they did recognise the explicitly propagandist purpose of the publications.[79] These writings therefore represent the official, public missionary thought, which in some cases differed considerably from private unpublished opinions. Although these public letters could with reason be analysed as missionary discourse, in this study they are referred to as missionary propaganda, in order to stress the difference between published and unpublished missionary sources. All missionary-written sources (with the possible exception of ethnographic studies by some missionaries), however, can be called "missionary language" in Mudimbe's sense.

Those scholars who have approached missionary medicine through discourse analysis have concentrated on missionary publications. They have developed stimulating analyses of missionary thought and language but have chosen not to study medical practice and the missionaries' actual interaction with Africans.[80] Methodologically, this is a safe approach, as the missionary publications are heavily edited, and the reality of their representations of African thought and action can be strongly questioned. However, the value of missionary sources, especially unpublished material, for an exploration of possible African intentions and interpretations should not be dismissed out of hand. Hunt has pointed out that the missionary-authored texts may reveal African interpretations and negotiations, and argues that historians should recognise the many voices of the colonized, and instead of trying to write one narrative of a "colonial encounter", historians should try to "imagine and render multiple transactions, mediations and misreadings."[81] Furthermore, as Ranger and Lonsdale have stressed, although African stories and voices might be more challenging to extract and interpret, Africans could still be given a narrative equality with Europeans.[82]

The Livingstonia archives contain particularly valuable primary material on missionary dialogues with the early African converts. From the turn of the twentieth century onwards, what eventually became the Church of Central Africa Presbyterian (CCAP) began to organise under missionary guidance. The Livingstonia Presbytery consisted of local congregations, the Kirk Sessions. The National Archives of Malawi holds a collection of congregational and Presbytery sources in Tumbuka as well as in English. Tumbuka eventually became the standard vernacular used throughout the Livingstonia sphere. This material enables the study of debates and discussions concerning health and

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79 In addition, Livingstonia missionaries wrote in locally published periodicals, *The Aurora* and *The Livingstonia News.*

80 Vaughan stresses the need for a separate study of missionary medical practice in Vaughan 1994b, note 57.

81 Hunt 1999, p. 160.

82 Ranger 1996, quoted in Lonsdale 2000, p. 8.

illness between the missionaries and African churchmen: elders, teacher-evangelists, preachers and reverends.

The early African church leaders are one important group of actors whose thought and action can be studied in some detail. Apart from the missionary sources and church records, and previous historiography, some of the leaders left written memoirs, correspondence, and texts, while others are remembered in oral accounts. The material provided by Levi Mumba and Yesaya Z. Mwasi is particularly important. The Watchtower preacher Elliot Kamwana has been studied by Chirwa and Fields, and the study of Livingstonia pupils and graduates in general has been pioneered by McCracken. These students and graduates can be regarded as intellectuals in a Gramscian sense – individuals with directive, organisational, educative or expressive social functions.[83] However, they form a small elite group and the vast majority of Africans who came into contact with the mission as patients, pupils, and therapy managers appear only as a passing reference in a missionary narrative if they appear at all. Notable exceptions to this include the local political leaders and their families, who formed an important patient/client group for the pioneer missionary doctors, and who feature prominently in Chapter 6. However, those who were outside the Christian community remain outside most missionary writing and much of the oral tradition of present-day Presbyterians in Northern Malawi.

In this thesis, the imagination of multiple interpretations is crucial. A historian with a piece of evidence from a missionary magazine, for example, which describes the actions of the African local healer, labelled a "witch-doctor" by the missionary, can hardly take the missionary narrative to be fact. But neither should it be automatically assumed that this missionary testimony is completely false. Through close and careful reading, and by situating the missionary narrative in context of other available sources, it may be possible to present probable interpretations and rule out others. Corroboration or contradiction from other sources makes the missionary archive more fruitful.[84] Often what can be deducted by contrasting different sources, however, may be a "misreading" of a missionary informant, but this has its own value. Furthermore, even if the study were to concentrate exclusively on missionary thought and action, it would have to take into account the influence of missionary interactions with Africans upon the missionaries themselves. As the Comaroffs noted, the colonial encounters also changed the colonialists.[85] The issues of African agency, perceptions, ideas and actions, with all the problems of historical interpretation, could not be overlooked even in a completely Eurocentric study.

A particularly important group of sources to be juxtaposed with the missionary archive are the anthropological studies of South-Central African societies from the late nineteenth century to the present day. These studies

83 Feierman 1990, pp. 17-27.
84 Arnold and Bickers 1996, p. 7.
85 See also Kirkwood and Ardener 1993, p. xix.

partially overlap with the missionary archive in the case of early missionary anthropologists and ethnographers such as D.C. Scott and T.C. Young. The anthropological material, based on field studies from the period 1875–1930 is considered to be primary source material, whereas later studies are considered to be secondary sources. The anthropological sources, of course, present their own problems, and must be approached through careful source criticism. The studies consulted are disparate in place, time and topics, and very few of them deal with medicine and healing as their main subject. The older studies in particular discuss illness, health and medicine as part of a study of religion or witchcraft. Read's study of the Ngoni, Marwick's and Van Breugel's work on the Chewa, and Wendroff's study on the Tumbuka all have relevance for this thesis, but there is no comprehensive anthropological account which adopts a historical perspective in its discussion of medicine, magic and religion in the Malawi region. As Gwyn Prins and van Binsbergen have noted, the question of how far a historian interested in dynamic social processes can "legitimately extrapolate backwards from the perceivable present form of the society in his interpretation of archival and oral materials", remains a considerable problem for the historical study of medicine and healing, as well as religion, in Africa.[86] Secondary anthropological sources have been consulted in conjunction with the primary sources to present some possible interpretations and to question others. However, they cannot provide a historian with easy solutions, reliable structures or cast-iron interpretations.

Steven Feierman has argued, in his critique of Janzen's study of Kongo therapeutics, that the most satisfying historical context for healing would be the "total history of local social organization and ideology", not a history of the change from "traditional" to "scientific medicine" nor a history of therapeutic pluralism. The aim should be "the history of the fundamental social institutions which control therapeutic choice". As Feierman notes, such an approach breaks down barriers between the study of healing and the general study of social life.[87] However, a single scholar is rarely able to write such an extensive history. In this work, Feierman's approach has inspired the study of the Livingstonia Mission and Presbyterian Church in Northern Malawi, as significant institutions with potentially influential ideologies.

The missionary archive is complemented by texts of early African Christians, oral sources, anthropological writings, missionary biographies,[88] official colonial sources and material provided by European settlers and travellers. This study's overall emphasis on European sources and the

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[86] Prins, quoted in van Binsbergen 1981, p. 19.Vaughan has also warned of the dangers of interpreting historical material on African healing systems through more recent anthropological studies. Vaughan 1994b, p. 200.

[87] Feierman 1985, pp. 82-83.

[88] Biographies of Robert Laws by W.P. Livingstone (1921) and Hamish Macintosh (1993) have been particularly valuable secondary sources. Despite the hagiographic nature of Livingstone's work in particular, they are based on the rich personal archive of Laws, and provide some important new insights into the history of Livingstonia. W.P. Livingstone also visited Laws in Livingstonia in 1920, and interviewed some of the African associates of the mission.

limitations of the oral sources must be acknowledged from the outset. As Karen Fields has noted, the image of events emerging from such an account is bound to be distorted and intermittent, with important gaps and blanks. In her study of Christianity and the Watchtower movement in colonial Central Africa, Fields stresses that, "The complete story will have to be told by African investigators able to question villagers in detail, in their own languages, and from their own standpoints".[89] This is also the case with the fuller story of quests for healing and contests for meaning in colonial South-Central Africa, a major historical narrative that this thesis aims to contribute to.

1.4 The aims of the study

The aim of this study is to gain a deeper understanding of how health and illness influenced the emerging colonial society in the Northern Malawi region, by integrating analysis of ideologies, images and ideas about health, illness and healing with the study of material aspects of life and practical experiences of illness and therapy. This is particularly important because of the potential of medicine to express moral judgements and values in "neutralized forms".[90] At the heart of the study are connections between medicine and morality: in missionary thought, rhetoric and action; in African local societies; in the Christian communities; and within the entire colonial society.

Unifying all the themes and questions raised in the thesis is the central concern of how the different ideas and actions taken to maintain and restore health of missionaries, Africans, and colonialists interacted with and influenced each other and the society and culture at large. In its study of therapeutic encounters, this thesis attempts to follow the three main processes outlined by Jordanova for the cultural history of medicine. Firstly, understanding what goes on between patients and practitioners. The local therapy management groups must also be included in this relationship. In the interaction between practitioners, patients and therapy managers, issues of communication, negotiation, reciprocity, rhetoric and trust are central. Secondly, analysing the ways in which relationships (such as divisions of labour) in the field of medicine and healing (involving practitioners, African "middles", patients, therapy managers, Christian communities and colonial authorities) were shaped and reshaped in changing colonial situations. Thirdly, understanding the cognitive dimensions of medicine, in which seeing and visualisation occupies a central position.[91] How did the hospitals and dispensaries work? What can be learned of the perceptions, relations and experiences of healers, patients and therapy managers?

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89 Fields 1985, p. 59; Cf. Good 2004, p. 29.
90 Jordanova 1995, p. 377.
91 Jordanova 1995, pp. 375-376; Romanucci-Ross et. al. 1991, pp. xiii-xiv.

In summary, this study is concerned with thought and action, ideas and socially constructed realities. This study aims to contribute to an understanding of missionary thinking and experiences of illness, health, healing and medicine and the positioning of missionary medicine in the wider context of cultural history of colonialism. Its potential to address the experiences of the African patients, therapy managers and healers is more limited, but still important. However, in the study of action and events in colonial situations, the study conceivably has greater scope to discuss African actions and experiences. In missionary medical practice, the healers, patients and therapy management groups involved are all vital actors who are considered. Close reading and thick description of medical encounters are crucial to this study.

The thesis structure is thematic, with each theme explored chronologically. Chapter 3 analyses the background of Livingstonia mission and its personnel as part of the late nineteenth-century Scottish medical missionary movement. As Arnold and Bickers have pointed out, the study of missionaries' background and their home society is a significant field of enquiry where the usefulness of the missionary archive has received surprisingly little attention. This requires careful reading and contextualisation.[92]

Chapters 4, 6 and 9 are largely concerned with therapeutic medicine and encounters between the missionaries and Africans. Chapter 4 charts the medical work of the Livingstonia mission, from the pioneering station at Cape Maclear to the sophisticated David Gordon Memorial Hospital and the network of smaller hospitals and dispensaries in the 1920s. It outlines the framework of curative missionary medicine in Livingstonia and assesses the scale and scope of medicine and surgery in the Mission. Chapter 5, which deals with the pioneer missionaries' quests to maintain their own health, studies both hygiene in the tropics and mission therapeutics during a period of extremely high mortality, 1875–1900.[93] One central reason for the deployment of the early Scottish medical missionaries to Central Africa was a concern about missionary health, what Andrew Walls has called the "utilitarian" motive. However, this was rarely mentioned explicitly in missionary publications, which stressed the medical and spiritual aid and relief given to Africans. Only private missionary correspondence reveals some of the concerns and difficulties the missionary doctors felt they were facing in their treatment of their colleagues, family members and each other.[94] Experiences of illness among the missionaries, as physicians, nurses and patients, are studied. The influence of the quest for health on the selection and construction of mission sites, mission politics and everyday living is examined alongside experiences of illness and therapy. Finally, the moral and psychological elements in missionary thought and action concerning the personal health of mission agents are considered.

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92 Arnold and Bickers 1996, p. 9.

93 During the period 1875-1900, eighteen missionaries, over one quarter of all the European members of Livingstonia, died and many others were invalided home. *Report of Foreign Missions for 1899*, pp. 18-19.

94 Walls 1982, p. 288.

Chapter 6 deals with early medical encounters between missionaries and Africans in Livingstonia. Firstly, it examines the role of medicine in the establishment of contacts between missionaries and local societies, medicine as a display of goodwill as well as power, and the role of the missionary doctor as a diplomat and consulting physician to the African elites. Secondly, it analyses the relationships and interaction between missionary practitioners, patients and different "therapy management groups".[95] Particular attention is paid to missionary surgery, notably chloroform operations, midwifery and amputations. In this study, "therapy management group" or "therapy managers" are taken as a generic terms, with the hypothesis that different variations of these phenomena can be identified in various pre-colonial and colonial South-Central African societies. The groups are thought of as fluid and variable, with the possibility that therapy management is sometimes decided by a single individual rather than a group.[96]

Chapter 7 concentrates on medicine and morality, and social and educational reform as preventive medicine/hygiene. It analyses Livingstonia missionary ideas about health and morality, the connections between moral, mental and physical, and the missionary perceptions of the health of African people and societies. The missionary programme for the creation of a morally, mentally and physically healthy Christian community is explored, and the connections between public and personal health, education, evangelisation and morality in Livingstonia are scrutinised. Due prominence is given to the thought of Robert Laws, and his ideas and policies concerning health, morality and education. The connections between morality and health in the thought and action of African evangelists and medical assistants, many of whom were educated at the Institution, are explored.

Chapter 8 investigates the perceptions and relations between missionaries, early Christians and African healers. Missionary doctors' views are presented alongside the writings of prominent clerical and lay missionaries. The missionary archive is supplemented by oral sources in an investigation into the relationships between missionaries, Christians and indigenous medical specialists. Chapter 9 analyses medical theory and practice, and the medical encounters in Livingstonia from the late 1890s to around 1930. During this period, missionary medicine emerges as an increasingly professionalized

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95 In his classic study, Janzen formulated the term "therapy management group" as a central and persistent phenomenon in the medical scene of central Africa. In Janzen's words, "A therapy managing group comes into being whenever an individual or set of individuals becomes ill or is confronted with overwhelming problems. Various maternal and paternal kinsmen, and occasionally their friends and associates, rally for the purpose of sifting information, lending moral support, making decisions, and arranging details of therapeutic consultation. The therapy management group thus exercises a brokerage function between the sufferer and the specialist…" Janzen 1978, p. 4. See also Feierman 1985, p. 78. Feierman suspects that in most parts of Africa, the therapy management group, not the patient, works out "a shared view of the clinical reality, with maximum tolerance of diversity".

96 Janzen distinguished the Kongo therapy management group from the "lay referring" agents of the West in that while the latter discharged its duties while the professional took over, in Zaire they continued to exercise their authority while the patient was treated by a specialist. Janzen 1978, p. 134, quoted in Feierman 1985, p. 81.

activity which concentrated on permanent hospitals and dispensaries, fixed spaces of healing. The emergence of African medical "middles" is examined in some depth. The exchanges, interaction, conflicts and co-operation between patients and their therapy managers, the middles and the medical missionaries are explored in detail.

Chapter 10 focuses on public health and colonialism, continuing the analysis of missionary and colonial quests for health in the early twentieth century. Furthermore, this chapter explores the relationships between the Livingstonia doctors and colonial authorities in Nyasaland and Northern Rhodesia and the critique of colonialism by both missionaries and African Christians. It analyses public health policies and measures at the Overtoun Institution in particular, and missionary responses to epidemics of smallpox, sleeping sickness, plague and influenza. Themes of power, coercion and the enforcement of health regulations in Livingstonia are paramount. The missionary and mission-educated African perceptions of health, morality, and the influence and impact of European colonialists and colonialism in the region are discussed. Particular attention is paid to the Mombera Native Association, a joint forum for Ngoni political elite and mission-educated Christians in the 1920s.

Chapter 11 shifts the focus from the missionaries to the emerging Presbyterian Church and the search for health and therapy among the pioneer African Christians of the early twentieth century. The discussions, debates and policies of the Livingstonia Presbytery and individual congregations are examined, along with the thought and action of individual church leaders. The role of African clergymen, evangelists, preachers and ministers, and their families in the search for health and therapy in local communities is analysed. As a case-study of pluralistic responses and attitudes to a particularly devastating epidemic, the influenza epidemic of 1919 in Northern Ngoniland, and its aftermath are examined with an emphasis on early Christian converts and their families, the missionaries, local healers and the *vyanusi* and the Christian cleansing movements of 1920. Influential former Livingstonia pupils who emerged as independent churchmen and their thought and action concerning medicine and health are studied in order to chart discourses about health and illness, and medical practices in the changing colonial society, and within independent African Christianity.

2 PRE-COLONIAL NORTHERN MALAWI, COLONIAL CONQUEST AND THE LIVINGSTONIA MISSION

2.1 Pre-colonial Malawi region and its medical culture

Political and socio-economic overview

European colonial and imperial occupation in the Malawi region during the late nineteenth century was the latest foreign invasion in a dynamic but turbulent century. The Lake Malawi region, which had largely formed part of the Maravi kingdoms in the sixteenth and seventeenth centuries, was in the early nineteenth century populated by predominantly agricultural societies of dispersed village settlements. The *lingua franca* from Kasungu to the present-day Mozambique border was called chiNyanja (chiMang'anja) in Southern Malawi and chiChewa in Central Malawi. The broad Chewa group was composed of different clans and groups, with major political and minor cultural variations. Linden has stressed that "the idea of the Chewa as a 'tribe' only emerged in the colonial period as the clans of Central Malawi needed to establish an ethnic identity" in the context of nineteenth-century Yao and Ngoni invasions and European conquest. Despite political divisions and some cultural differences, a common language, history and culture united the Chewa.[1]

The Maravi peoples were matrilineal. In the Chewa family and lineage system, the maternal brother was a significant figure and in Kings Phiri's words was, "the guardian (nkhoswe) to his sister and her offspring, and the sustainer of their social, economic and legal interests."[2] The guardian looked after the

[1] Linden 1974, pp. 1-2; McCracken 2000, pp. 29-32; Schoffeleers 1979, pp. 147-178. In Central Malawi, the most important clans were the Banda and the Phiri. The powerful Mbona and Chisumphi territorial cults extended over the whole area populated by the Mang'anja-Chewa.

[2] Phiri 1982.

general welfare of his dependants, duties which usually belonged to the father among the patrilineal peoples. In the Malawi region, mothers, grandmothers, kin and non-kin networks, and village headmen and chiefs, as well as guardians, were all influential participants in therapy management.[3]

To the north of the Maravi kingdoms, the Tumbuka and related peoples populated the area to the west of the lake and the Tonga, the western lake shore. Both groups, with their own distinct languages and tribal identities, had formed as the result of continuing migration and the gradual amalgamation of several different groups. At the northern end of the lake, the Ngonde (related to the patrilineal peoples of western Tanzania) had settled on the Karonga plain, and established a centralised state, led by Kyungu, a religious and political leader.[4]

The peoples of the Malawi region were skilful agriculturalists, growing, among other crops, maize, sorghum, millet, beans, rice, pumpkins, cassava, sweet potatoes, tobacco, and hemp. Cattle were scarce, and the majority of livestock farmers kept goats and sheep. Livingstone observed in the 1860s that in the Shire Highlands cotton was grown in almost every village. Furthermore, iron ore was mined and manufactured in both northern and southern Malawi. Local trade was extensive, and important trade goods included iron, tobacco, salt, dried fish, animal skins, medicines and poisons.[5] There was distinct economic and professional specialisation within the village communities. For example, among the Mang'anja in the Shire Highlands, there were specialists in most villages who produced iron, salt, bark-cloth and pots, but they were apparently not much wealthier than their non-specialist neighbours. Common mediums of local exchange included fowls, goats, and sheep. The chiefs had ritual powers and responsibilities over matters of health and the fertility within their kin group.[6] Although agriculture, industries and trade had flourished in the region, there were also recurring problems of poverty, hunger and disease. John Iliffe has argued that the majority of nineteenth- and early twentieth-century Malawians suffered from "a debilitating but non-fatal poverty", and a considerably smaller proportion were "very poor", living in a state of chronic want. For the agriculturalists, famine was the most feared calamity.[7]

Three major groups of traders and invaders had entered the Malawi region by the mid-nineteenth century: the Swahili from the east, the Yao from

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3 Marwick 1970, p. 145. In cases of illness, the guardian's responsibilities could include arrangement and payment for the consultation of a diviner, obtaining medicines, organising a propitiation of a spirit or a prosecution of a sorcerer or a witch. I am grateful to a Malawian medical anthropologist, Dr Alister Munthali, for valuable information supplementing this chapter. Interview with Dr Alister Munthali, June 2004.

4 McCracken 2000, pp. 29-32; Vail 1979, pp. 209- 223. The Tumbuka patterns of marriage, descent and inheritance were complex. The northern Tumbuka were mainly patrilineal and virilocal, while southern Tumbuka (Tumbuka-speaking people of today's Mzimba district) were mainly matrilineal and uxorilocal.

5 Chavula 1976; McCracken 2000, pp. 32-33; Phiri 1984.

6 Vaughan 1978. Kin groups of Mang'anja were not insular, but potentially broad groupings which could extend far beyond the immediate family.

7 Iliffe 1984, pp. 245-251.

the south-east and the Ngoni from the south (via a detour to the north). The Swahili and the Yao were traders whose predominant interests were ivory and slaves. Using firearms obtained through trade, they were able to dominate large areas of indigenously farmed land. In the 1840s, Salim bin Abdallah, a trader from Zanzibar, settled in Nkhotakhota on the western shore of the lake, a growing trading and agricultural centre, and became an established regional ruler under the title of Jumbe. By the late nineteenth century it was estimated that between ten thousand and thirty thousand slaves were transported across the Lake Malawi to Kilwa and Zanzibar each year. In the southern part of the country, groups of Yao from Mozambique had initially settled largely peacefully among the Mang'anja but eventually took over the Shire Highlands by force, making the Mang'anja their subjects or driving them to the Shire valley. The Yao had much in common with the Maravi peoples, being matrilineal and matrilocal subsistence farmers. However, their trading connections with the coast brought significant cultural changes to the lake region, including important Islamic influences. Makanjira and Mponda, leading Yao chiefs, had formed major settlements with several thousand inhabitants by the time the first Scottish missionaries arrived in southern Malawi.[8]

In contrast to the Swahili and the Yao, the patrilineal Ngoni were not traders but martial pastoralists who swept over large parts of Southern Africa, moving northwards after they split from the expanding Zulu empire in the 1820s. Their superior military organisation and tactics, under the leadership of the paramount chief Zwangendaba, enabled them to subjugate several groups of northern peoples, who were incorporated into Ngoni society. The Ngoni advanced as far north as Ufipa, on the east side of Lake Tanganyika. However, after Zwangendaba's death in the mid-1840s, a succession dispute followed, and the Ngoni broke into several groups who moved in different directions and subjugated new peoples. By the 1870s, four independent Ngoni kingdoms had been established in the Malawi region. The most significant of these for Livingstonia was the northern group, led by M'mbelwa, which advanced from the north into the Henga valley, conquered most of the Tumbuka groups and finally settled in the hills to the west of the lake. The Ngoni economy was based on cattle rearing and raiding for supplies and captives. The captives supplied the necessary manpower for the Ngoni regiments, which formed the backbone of the state. A captive who proved to be a successful warrior could rise through the ranks into the military and political leadership.[9]

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8 Good 2004, pp. 50-51, 67; McCracken 2000, pp. 33-35; Phiri 1982; Phiri 1984.

9 McCracken 2000, pp. 35-37. In 1886, Walter Elmslie described the Northern Ngoni society as consisting of a small group of "true Ngoni", of the royal Jere clan, numbering about two hundred, the "freed slaves" who regarded themselves as Ngoni, and the occupied "slaves", mostly Tumbuka. Elmslie to Cross 8 January 1886. NLS, Acc. 9220 (i), (iv). In this thesis, following T.J. Thompson, the term uNgoni (from Ngoni and Tumbuka languages) is used to refer to "the area where the Ngoni lived, and over which they had immediate control." In this work, it is used exclusively for Northern Ngoniland. As missionaries referred to this area as Northern Ngoniland, it is used interchangeably with uNgoni. Similarly, uTonga and Tongaland are used interchangeably.

For all these intruding groups, people were a commodity and a source of wealth and power, and subjugated people were required for manual and military labour. The Swahili and the Yao traded in slaves, while the Ngoni captured people for their regiments and society. To be successful, traders needed firepower, mercenaries, and military skills, and were in practice often warlords who carved their own polities through violence. For chiefs such as Mponda, their power was based on people and trade. Chiefs accumulated women as symbols of power, wanting to build a store of "traditional" wealth in the form of people.[10] The agriculturalist groups suffered heavily from these invasions. The slave trade and Ngoni raids deprived village communities of their labour force, and people were forced to abandon large areas of land concentrating instead in large stockades, or moving to mountains, swamps, and other places of shelter. New and existing human and animal diseases spread along the new trade routes as contact with the coast and Europe increased. Charles Good has argued that "deadly epidemics among populations with little or no immunity" must have broken out in the region. Agriculturalist communities suffered significant loss of life, labour and independence, endured political and religious upheaval, as well as the disruption of agricultural production and pre-existing trade networks, as a result of the nineteenth–century invasions.[11]

However, not all the effects of the nineteenth-century invasions were negative. Destruction and war were not universal features of the region, as was often claimed in early European accounts of the region. The long-distance trade connections of the Yao and the Swahili brought with them new economic possibilities and prosperity for some groups and individuals. The Ngoni occupation of the north led to the establishment of a centrally ruled state, which provided order, protection and the possibility of advancement through a military career, artisan or ritual specialisation for those who were incorporated into or allied with the Ngoni state.[12] Furthermore, not all agricultural communities were subjugated. Some formed successful alliances with the invaders, while others resisted, or managed to avoid, attacks. Mwasi Kasungu, a Chewa paramount, defeated an Ngoni attack in the 1860s and afterwards formed an alliance with M'mbelwa, securing independence in exchange for military aid. On the lakeshore, the Tonga were frequently attacked by the Ngoni, and a number of them were captured, but the Tonga retained their independence, and fortified themselves within large stockades on the shore. During the 1870s, the Tonga captives rebelled and fled to the stockades, which created considerable tension between the Ngoni and the Tonga at the time of the missionaries' arrival. At the north end of the lake, the Ngonde remained independent and lived largely in peace until the late 1880s.[13]

Historians have stressed the fluidity and complexity of political and social interaction between different groups in Malawi prior to European arrival. Those

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10 Vaughan 1978.
11 Good 2004, pp. 53, 230.
12 McCracken 2000, pp. 33-41; Rau 1979.
13 McCracken 2000, pp. 40-41; Oliver 1952, pp. 113-115.

"tribal" groups did not represent distinct, homogenous political entities. McCracken has argued that, to some extent, "tribal labels indicated economic, not ethnic identity".[14] In the study of religion and ideas as well as politics and economy, the category of "tribe" has not been a particularly fruitful unit of analysis. Leroy Vail has emphasised that in northern Malawi, religious ideas, patterns and institutions were moving, changing and interacting across the linguistic Tumbuka-Chewa border well before the Ngoni conquest. Trade, intermarriage and small-scale migration connected the Tumbuka, the Tonga and the Chewa, and there was ongoing cultural exchange before the nineteenth-century invasions.[15] In conclusion, in McCracken's words, "Malawi by the 1870's was less a land of chaos than of fluidity, with confusion resulting not from the absence of political systems but from the presence of too many clashing and competing systems."[16]

Religion, public health and medical culture

In pre-colonial Africa, religion, medicine, ecology, politics and socio-economic conditions were closely linked and, as Steven Feierman has warned, any attempt to define the pre-colonial field of healing "raises difficult questions about medicine as an ethnographic category". If, for example, illness and death are believed to be caused by evil in society, then "anyone with the moral authority to assess the causes of evil was a health worker, and conversely every healer of substance was concerned with social order and disorder. This meant...that the roles of healer, of political authority, and of ritual specialist all overlapped and in many cases fused with one another…"[17] Feierman stresses that there was not one typical pre-colonial African pattern: the roles of chiefs, ritual specialists, healers and kin groups varied considerably locally and regionally. To discuss pre-colonial medical culture in the Malawi region, then, requires care and an awareness of healing not as a narrowly defined area of specialisation but as a broad cultural area of thought and practice, inseparable from many other aspects of society.[18]

Most indigenous agriculturalists in the Malawi region shared three basic religious beliefs that were widely-held across the whole of South-Central Africa. Firstly, the belief in spirits, worshipped through various cults, was universal. According to Gloria Waite, among the pre-colonial Bantu-speaking peoples of East-Central Africa, the spirits of the community's founders ("territorial" or

14 McCracken 2000, p. 42. Alliances were formed between the Yao chief Mponda and the Ngoni chief Chikuse against Mponda's trading rival, Makanjira, a Yao chief of Chewa origin, for example.

15 Vail 1979.

16 McCracken 1968, p. 103.

17 Feierman 1985, p. 116. See also Waite 1992.

18 As Good notes, from the perspective of a study of health ecology in African history, factors of location are "critical determinants for a society's risk and wellness", making local and regional variations as crucial as they are in cultural or social historical analysis. Good 2004, pp. 223-224.

"tutelary" spirits) were propitiated only by the political and religious elite, chiefs, kings and priests, for communal welfare and especially for rain-making. These activities affected whole communities and clearly belonged to the sphere of public health. In contrast, the family elders propitiated family spirits in private, in cases of familial illness and other misfortunes. Secondly, there was the belief in a High God or snake deity spirits, who were regarded as being more remote than the spirits of men, and who were worshipped through important territorial cults.[19] Thirdly, people commonly believed in the existence of witches or sorcerers, who were responsible for misfortune, sickness and death. There were a number of ways of detecting malevolent witches and sorcerers. A widespread method of detection among the indigenous agriculturalists had been the *mwavi* or *mwabvi* poison ordeal. The Yao and the Ngoni shared or adopted these beliefs and practices, and took over the control of the poison ordeal from the conquered people. Thus, by the time the missionaries arrived, the poison ordeal was commonly used by the Ngoni, the Tonga, the Tumbuka as well as by the Chewa, Mang'anja and Yao.[20]

In pre-colonial disease aetiology various spirit possession illnesses were situated between those illnesses caused by community spirits and those caused by family spirits. The treatment of these illnesses did not necessarily involve the entire community, but they were treated in public, usually through dancing and music, particularly drumming. As Vail notes, a distinct "peripheral spirit possession now embodied in the *vilombo-vimbuza-vyanusi* complex" existed from at least the late nineteenth century in Northern Malawi and Zambia. Spirit possession was stimulated in the Ngoni states by captives and subjugated peoples. Cases of spirit possession would be treated by specialists.[21]

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19 Rau 1979; Vail 1979; Waite 1992, pp. 214-215. For example, among the southern Tumbuka, the central intermediary spirit of the High God was Chikang'ombe, who controlled rains, and who on Earth took the form of a huge snake. Among the Chewa in the south, the mythical snake Thunga had a central place within the rain-cults. The northern Tumbuka believed that powerful spirit entities resided in large trees, rivers with rapids, and mountains with mists and rain. They were usually not approached directly, but rather through ancestral spirits who acted as intermediaries, referred to as *Vibanda*, and who were often prayed to in front of the *Kavuwa* temples. Soko 1987, pp. 10-11.

20 McCracken 2000, pp. 42-43; Chavula 1976; Schoffeleers 1979; Vail 1979; Vaughan 1978; Waite 1992, p. 218. A territorial cult can be defined as a "cult whose constituency is defined by common occupation of a particular land area, so that membership of the cult is...a consequence of residence and not kinship or ethnic designation." The spirit entities in Central Africa can be classified as 1) historical spirits, 2) ahistorical spirits, such as snake deities and High Gods, who never lived as humans on earth and 3) parahistorical spirits who are human in form, but are strangers and prophets, coming from outside the community and its known lineage connections. Schoffeleers 1979, pp. 1, 11-13.

21 Rau 1979, p. 136; Vail 1979, p. 213; Waite 1992, p. 215. According to Soko, the *Vimbuza* phenomenon in modern times is a blanket term covering three distinct types of spirit-possession disease: *Vimbuza, Virombo* and *Vyanusi.* These terms are also used for the corresponding cults, ceremonies and dances, which are treatments for these diseases. These spirits are commonly regarded not as ancestral, but are largely attributed to outsiders. The phenomenon is believed to have developed during the nineteenth century as the result of contact between various groups. The symptoms of *Vyanusi* include "abnormal behaviour which can lead to madness if not attended to in time; *Virombo* involves heart palpitations and severe headaches; and *Vimbuza*

Public health control

In his doctoral thesis, John Lwanda has argued that in pre-colonial Maravi culture, to ensure stability, order and health, societies had developed "complex socially formative and normative constructs, myths, beliefs and taboos integrating religious, economic, political and cultural elements." Religious and political authority were closely connected, and the rituals of harvesting, planting, births, puberty, death and prayers for rain were central to communal health. Drought and epidemics could result from individual or communal moral transgression. Religious authorities were spiritual mediums, who often possessed rain-making powers. Politics, religion, ecology, morality and medicine were closely connected, particularly in times of communal health crises. Throughout the Malawi region, rainfall was uncertain and recurring famines were a major threat to public health, making the rain cults crucially important within the society. The political leaders' authority often depended on their control of the rain-making mediums. During a time of epidemic or drought, the kings, chiefs and other "guardians of the land" strove to bring the institutions of spirit worship, healing practices and witchcraft eradication under their control.[22]

Matthew Schoffeleers has argued that in Central Africa, territorial cults concerned with rain, affliction and other vital issues of the land, formed a comprehensive, "ritually directed ecosystem". However, Feierman has warned that for the history of health, such a model would be too all-encompassing as "No cult was ever the entirety of a system of health."[23] The descendant of

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involves generalized body pains." *Vyanusi* is believed to stem from contacts between the Ngoni and the Tumbuka, *Virombo* from contacts between the Chewa and the Tumbuka, and *Vimbuza* from contacts between the Bemba/Bisa and the Tumbuka. Treatment for *Vimbuza* and *Virombo* is similar to therapy for psychosomatic diseases, while *Vyanusi* treatment "is oriented more towards witch-smelling and divination". A serious *Vyanusi* spirit possession may, if treated properly, result in the victim's eventual graduation as the community diviner and healer. The *Vyanusi* possession seems to have become increasingly common in Northern Ngoniland during the early twentieth century, following the formal abolition of the poison ordeal by the colonial authorities. This suggests that *vyanusi* may have been regarded as a replacement for the *mwabvi* ordeal. Soko 1987, p. 9. According to Vail and White, *Vimbuza* spirits, who dealt mainly with social problems, were originally the spirits of warriors slain in late nineteenth-century wars, while *Virombo* spirits were powerful animal and reptile spirits, who dealt with cosmological problems. In contrast, *Vyanusi* spirits had been powerful witch-finders in life, and led the possessed to accuse others of witchcraft and to deal with it. *Vimbuza* occurs predominantly among women; it has been estimated that over seventy per cent of Tumbuka-speaking women in Malawi and Zambia experience it. Vail and White 1991, p. 231-239.

22 Linden 1974, p. 2; Lwanda 2002, p. 60-61; Schoffeleers 1979; Waite 1992. For example, in witchcraft eradication, competing methods of spiritual divination, practised by priest-diviners, and the poison ordeal, a technique controlled by kings and chiefs, were central in the political conflicts in the Kalonga kingdom in southern Malawi and Mozambique during the sixteenth century.

23 Schoffeleers 1979, pp. 1-11; Feierman 1985, p. 117. Schoffeleers distinguishes "ecological" from "non-ecological" cult functions. Non-ecological functions include political, divination, healing, and charismatic functions. However, from a holistic public health perspective advocated by Feierman, ecological functions can be largely regarded as public health functions as well.

Mwabanga, the Phoka cult leader in Manchewe on the Khondowe Plateau stated in an interview that in the past, special prayers and cult ceremonies had been resorted to in times of drought or epidemic, but not in individual cases of illnesses which were treated by the *asing'anga,* the healers.[24]

Lwanda has summarised the pre-colonial Maravi theory of disease prevention as "a mixture of morality, social and political engineering and religion". The public health system included communication with, and appeals to spirits, the maintenance of public taboos, the breaking of which resulted in illness, and medical measures such as variolation against smallpox. Furthermore, music, dance, and various "formative rituals" had important functions in the maintenance of public health. Sanitation measures used by pre-colonial societies included waste disposal, burning houses following deaths caused by certain illnesses and village relocation.[25]

Theories of disease, medical specialisation and therapy management

"Hot" and "cool" were particularly important concepts in Central African medical theory. Certain illnesses were regarded to be "hot" and contagious. For example, the neuropathic ulcers and swollen tissues common in leprosy (which was a common disease across the lake region) were considered to be "hot". People who were "hot" could be isolated, and contact with their bodies was avoided. Isolation, variolation and special burial practices were employed to combat the spread of smallpox, a major epidemic scourge, but again methods and practices varied locally. Smallpox inoculation or variolation had been administered, at least in the Shire valley, before European arrival. When faced with serious famine, the society could ultimately respond with mass migration.[26]

Corresponding to the beliefs in spirits, a High God and witches, were theories of diseases attributed to spirits, the High God, or witchcraft. Terence Ranger has argued that most pre-colonial African societies divided illness into two categories in their theories of illness: the diseases of God and the diseases of Man. The "diseases of Man" resulted from moral transgression of some kind. They included illnesses caused by the sufferer's own moral transgression as well as illnesses caused by a malevolent evildoer: the witch or the sorcerer. In this scheme, therefore, illnesses caused by ancestral spirits, spirits of the land, the breaking of taboos, and witchcraft, all belonged to the broad category of "diseases of Man".[27]

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24 Oral testimony, S.M., 11 July 2004.

25 Lwanda 2002, pp. 65-67; Waite 1992, p. 216.

26 Good 2004, pp. 238-240; Herbert 1975; Iliffe 1984, pp. 249-250; Linden 1974, pp. 30-31; Lwanda 2002, pp. 65-67; Laws to Russell 19 May 1875. Wellcome Institute Library, MS. 5143/30/1. Among the lower Shire peoples, for example, dead lepers were hung from trees to "cool" before burial. However, the treatment of lepers varied greatly. Often they were cared for in the early stages of disease, but in cases of severe leprosy, they would be abandoned.

27 Janzen 1978, p. 8. and *passim.* Ranger 1982, p. 339; Ranger 1981.

In contrast, “diseases of God” were, in Ranger’s words, “regarded as tolerable, ‘natural’ part of the divine plan. They could not sensibly be resented; no special explanation was necessary to account for them; they were properly treated by secular herbal remedies...Paradoxically, then, diseases of God were the sphere of herbal and other secular remedies; diseases of Man were the sphere of *spiritual* treatment of diseases, since the afflictions themselves were caused by the actions of spirits.” According to this model, specialists in the illnesses of God would be “secular” herbalists, while the illnesses of Man were the preserve of spiritual or witchcraft specialists, who through sacrifice or other actions appeased the spirits, practised social healing by restoring troubled relationships within the family, kin group or village, or who detected and neutralised the witch/sorcerer. Initially, however, the underlying cause of a persistent illness had to be ascertained.[28]

The spirits of the dead were the intermediaries between this world and beyond, and the role of spiritual specialists, diviners *(nchimi)* or prophets, was to communicate with the spirits and to view the past, present and future of the community. Through divination the cause of an illness could be diagnosed and a suitable therapy chosen. The territorial cults had leaders and specialists who were in charge of the regional shrines and sacred places. Territorial spirits were approached in cases of communal crises such as drought and epidemics. Finally, there were specialist witch-finders and witchcraft eradicators. The poison ordeal was administered by a specialist who knew how to prepare poison from the bark of the *mwavi* tree. Other specialists included the Ngoni *vyanusi* (*itshanusi)*, “smeller” (a term translated as diviner, doctor or a prophet) who could identify troublesome ancestral or alien spirits or witches. All these specialists could practise divination or therapy to discover the cause of a communal or individual illness, or to neutralise it.[29]

Ranger’s classic generic classification of pre-colonial African theories of disease causation is an indispensable starting point of this study. However, further points based on anthropology of medicine in the Malawi region need to be made when considering healing in local, micro-level analysis. Firstly, as anthropologist Brian Morris has stressed in a modern study of Chewa conceptions of disease, it is important not to conflate nosology (the principles behind classification of disease) with aetiology (the underlying causes of disease). Morris has argued that “there are no witchcraft “diseases” in Malawi, only certain kinds of misfortunes which may in specific contexts be attributed to witches *(afiti)*”. Although the nosology and aetiology cannot be strictly demarcated, it is important to keep the distinction in mind, in order to avoid the Western missionaries’ and anthropologists’ earlier and erroneous tendency to view all or most diseases as being caused by witchcraft in Malawian medical thought. Nineteenth-century Malawians had a rich vocabulary to describe various bodily ailments. D.C. Scott’s chiMang’anja dictionary listed seventy-five different disease categories in use in the 1890s, while, in the early twentieth

28 Ranger 1982, p. 339; Cf. Janzen 1978, pp. 8-9.
29 Lwanda 2002, p. 65; McCracken 2000; Rau 1979.

century, doctor and ethnographer Hugh Stannus listed almost one hundred disease conceptions used by the Yao in the Zomba district.[30]

Secondly, an individual's illness can move from one category to another as the diagnosis changes. A typical pattern is an illness which is at first thought to be "normal" and non-threatening, and treated, if at all, by home remedies or by someone in the village who has knowledge of medicinal plants, without recourse to specialist healers. If the illness turns out to be severe, chronic, or persistent, it is then diagnosed by specialist A, as caused by X, requiring therapy 1. If the therapy is not found to be effective, the diagnosis may change to Y, and therapy to 2, and more specialists (B, C…) may be involved in the process. Furthermore, several therapies may be in use at once. Such patterns can be discerned in both the early missionary accounts of indigenous medical practice in the Malawi region as well as in the recent anthropological studies.[31] A typical example of a "disease" concept that is essentially an "etiological category which is invoked to cover a variety of ailments that may have failed to respond to other forms of therapy" is the *virombo-vimbuza-vyanusi* spirit possession complex.[32]

Thirdly, Morris emphasises the general complexity of African theories of nosology and aetiology, and Chewa conceptions of disease causation in particular. He singles out four distinct disease complexes: 1) the diseases regarded as "natural" or indirectly attributed to a High God (*mulungu)*; 2) the diseases related to some moral or ritual transgression; 3) those associated with either witchcraft *(ufiti)* or sorcery (*matsenga)*; 4) illnesses associated with spirit entities, notably neglected ancestral spirits or harmful foreign spirits, which are treated with complex rites and cult activities. Morris argues that although many deaths may be attributed to moral transgression, witchcraft or spirits, the Chewa essentially regard many non-fatal ailments in "natural" terms.[33]

Fourthly, it must be emphasised that the details of pre-colonial medical specialisation in the Malawi region remain unclear, and the picture emerging from early European accounts and later anthropological studies is complex. The following is, then, only a general hypothesis based on these secondary sources. Lwanda has argued that although theories of disease causality mirrored the "'religious' trichotomy" (spirits–High God–witches) religious aspects were, and

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30 Morris 1985, pp. 16-19. Western scholarly fixation with illnesses caused by witchcraft has endured beyond the colonial period. For example, Linden asserted in 1974 that for the Africans in early twentieth-century Malawi, "disease was always assumed to be caused by some human, usually magical, agency..." Linden 1974, p. 60.

31 Elmslie 1899; Fraser 1922: Young 1931: Morris 1985. Cf. Feierman 1990, pp. 103-105, 255.

32 Morris 1985, pp. 23-24, quoting Soko; Soko 1991, p. 28.

33 Morris 1985, pp. 17-19. Morris stresses that although God may ultimately be held responsible for afflictions, the herbalists he interviewed rarely mentioned God as a causal agent. According to Morris, there is no concept of "nature" as such in chiChewa. He argues that the Chewa healers describe illnesses in "essentially naturalistic terms". Morris discusses in detail the important concept of *tsempho/mdulo*, a wasting disease of category 2. It affects men, women and young children, and is caused by another's, not the sufferer's, moral or social transgression, particularly promiscuous sexual relationships or sexual intercourse between spouses during prohibited periods. It is notable that *tsempho* is a disease resulting from moral transgression that does not involve a spirit entity, deity or a witch.

are, only part of the medical culture as a whole. People were aware of illnesses that had not been caused by witchcraft or ancestral wrath, and had a number of therapeutic and prophylactic treatments for these diseases. However, it is difficult to distinguish clearly between "secular" or "natural" and "sacred" or "mystical" form of therapy. The spirit mediums often possessed a considerable variety of herbal medicines, and sacrifice to spirits could be combined with treatment using "natural" medicines.[34]

It is difficult to determine to what extent pre-colonial healing specialists could be classified as "religious" or "secular" practitioners, or both. Later evidence suggests that a diviner (*nchimi)* might also provide herbal medicines, or that a single healer (*ng'anga*) could diagnose the cause of illness, provide herbal medicines, fortification against illness and protective medicines against witchcraft, or arrange a dance to deal with illness-causing spirit possession. Furthermore, the knowledge of "secular" herbal medicines was frequently understood to have been transmitted by ancestral healers through dreams. The preparation and administration of such medicines often involved lengthy religious and ritual processes.[35]

Early commentators on African medicine displayed an ethnocentric fixation with practices connected to witchcraft, which limited their observations of other forms of therapy. T.C. Young believed in the 1930s that the profession of *ng'anga* remained strong, while at the same time it was changing.[36] How healing specialisation within the region actually changed during the nineteenth and early twentieth century is beyond the scope of this enquiry, but the potential dynamism, mobility and fluidity of healing specialisation must be borne in mind. Marcia Wright has provided a biographical account of a Sangu priest-doctor, *mganga,* named Namesa, the daughter and apprentice of a famous doctor in the Southern Highlands of Tanzania, to the north-east of the Malawi region. She became a refugee during the Ngoni invasions of the mid-nineteenth century, and she set out on a wandering life with an inherited satchel of her father's medicines. She travelled as far as the Indian Ocean and learnt Swahili and many other languages. It seems that peripatetic medical specialists were able to cross political and ethnic frontiers with comparative ease. Wright has argued that in the late nineteenth-century Southern Highlands of Tanzania, "the strengths of one school of medicine and magic could also be valued by

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34 Lwanda 2002, p. 63; Morris 1985, p. 15 and *passim.*

35 Good 2004, p. 421; Mackenzie 1925, pp. 272-273; Young 1931, pp. 29-31; Morris has stressed that in the modern context, many herbalists in Malawi, as elsewhere, do not practise divination. Morris 1985, p. 16; Morris 1985, "Additional note on herbalist associations", pp. 37- 38. For an early description of the training of a healer in northern Ngoni society, see Elmslie 1901, p. 67. Mackenzie (1925, p. 273) provides a description of a well-known Ngonde healer, Mwenekansangamara, praying to the Creator while gathering roots. In the prayer, if the roots are not to be found, it is the Creator's will. Furthermore, Mackenzie quotes another prayer used by Ngonde healers: *"If this disease has come from God, medicine will heal it; for God, who made us, made also the trees, and gave us intelligence to know their properties. But if it has come from men, I cannot heal it."*

36 Young 1931, pp. 29-31.

peoples predominantly served by another school".[37] There is a case to be made for the existence of a pre-colonial medical pluralism in the Northern Malawi region, which partly overlaps with Wright's area of study. As Ranger has noted, Central African societies in general were open to new myths and rites, symbols, and techniques. Furthermore, the notion of "mystical geography" – the recognition of "special power to areas outside one's own and which often emphasized the mediating or cleansing role of an uncommitted outsider" – was widespread, and pioneer missionaries were often viewed as potential mediators of such outside power.[38]

To summarise, although pre-colonial healing was closely linked to prevailing religious beliefs, healing was by no means restricted to religious specialists. There were a variety of individual as well as communal responses to illness. Firstly, anyone could have knowledge of local medicines (herbal or otherwise) to treat certain ailments. Secondly, although an individual or a family might have knowledge of a medicine or a therapy for a certain illness, they would not be regarded as specialist healers as such. Thirdly, there were specialist healers, who could perform diagnostic and therapeutic as well as prophylactic functions; they could be diviners, religious specialists, or witch-finders. Likewise, they could be men and women of political authority. What distinguished the *wang'anga* was their wide range of medicines, *mankhwala,* and in English translation, a healer, doctor, or a "medicine man or woman" might be the most appropriate generic term for these healers. "Witch-doctor", the common Western name for African healers during the colonial era is often misleading and laden with colonial overtones, but would be more correct for those specialists dealing with illnesses caused by witchcraft. The healers were often in charge of essential community rituals. Midwives were in charge of births and infant care.[39]

In the case of illness, therapy management was (and is) a communal affair. In his novel (translated by T.C. Young and published in English in 1934) which described life in early twentieth-century Malawi, Samuel Y. Ntara provided a valuable account of therapy management among the Chewa. In the matrilineal community, the role of the mother's brothers as guardians of the children is significant, but the father also has therapeutic responsibilities: he must provide medicines for his children. The father himself is taken ill with a severe headache and is treated using various medicines brought by ordinary people. When these do not help, the wife turns to her (and the headman's) younger brother, who is the guardian of the women of the family, and asks him to approach the family of her husband, so that both sides can consult a diviner together. The diviner determines that the cause of the illness was a dispute between the wife and one of her brothers. Despite attempts to reconcile the ancestral spirits, the ailing

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37 Wright 1971, p. 33, quoting Kootz-Kretchmer, Elise, "Die alte Zauberin" (Herrnhut, Nachlass Koontz-Kretchmer). For pre-colonial medical pluralism in Tanzania, see also Feierman 1990, pp. 101-105.

38 Ranger 1975, p. 9.

39 Good 2004, pp. 23, 256-259; Morris 1985, 1986; Scott 1897, pp. 315-316; Young 1931, pp. 28-30.

man dies and ultimately his wife's brother, whose animosity caused the illness, pays the settlement.[40]

Mankhwala

In Lwanda's words, in the Malawi region, "Mankhwala (medicines) has a much broader meaning than 'medicine' in western medicine, including herbs, lotions, potions, charms, and all positive healing agents, as well as all paraphernalia of witchcraft".[41] Beyond healing and harming, *mankhwala* could be used to ensure success in war, agriculture, hunting, court cases and generally most areas of life requiring security, restoration or growth. D.C. Scott argued that in Central African thought, both the healer and the witch/sorcerer acquired their potential through the power of spirit *(mzimu)* – contact with the spirit world of the deceased – and that both "medicine power beyond medicines proper" and the "supposed mfiti power" were considered to be "just a stage higher in spiritual power than that of ordinary human activity".[42]

Early European writers such as the anthropologist Alice Werner noted that the term *mankhwala* referred to both "charms" as well as "medicines". In Western classification, "charms" operate by magic, while non-magical "medicines" are considered to have "natural" healing properties. These specialists in "medicines" would usually be referred to as "herbalists" in English. Many herbal medicines were laxatives or astringents, and were generally considered to be effective by Dr Howard of the UMCA in 1908. D.C. Scott noted in 1897 that charcoal was commonly used to paint wounds and ulcers, and that several caustic medicines were used to treat ulcers, many of which were applied directly to the wound. In addition to providing medicines, the healers also used treatments such as bleeding, cupping, counter-irritation and massage. Among the Ngonde at the north end of the lake, autopsies were sometimes carried out to discover the cause of an individual's death.[43]

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40 Ntara 1934, pp. 27-37; 43-48.

41 Lwanda 2002, footnote 71; It appears that witches and sorcerers in the Malawi region, at least in the north, caused illness and death exclusively through the use of substances, "bad medicines", and not through any bodily "emanations" such as those described by Evans-Pritchard in his classic study of the Azande. Wendroff has argued that according to Evans-Pritchard's classification, their practices would be classed as "sorcery" that is, doing someone "ill by performing magic rites by bad medicine". However as "witchcraft" is the standard English translation of the Tumbuka word *ulowe*, in this thesis it is preferred as a general term. As possession of potentially lethal medicines is not criminal as such and their use may be justified in some situations, there arguably exists a grey area between a medicine man/woman and a sorcerer or a witch, a "death-dealer" to use T.C. Young's term. Anti-theft medicines harmful to the intruder or the adulterer, for example, are widely considered to be legitimate. Morris 1986; Evans-Prichard 1937, p. 21, quoted in Wendroff 1985, pp. 21-24; Mackenzie 1925, pp. 251-291; Young 1931, pp. 28-31. See also Marwick 1970.

42 Rau 1979, pp. 137-138; Scott 1897, pp. 315-316, 415-416; Wendroff 1985, p. 24.

43 Good 2004, p. 259; Morris 1985; 1986; Mackenzie 1925, pp. 284-285; Scott 1897, pp. 315-316; Young 1931, pp. 28-30.

Echoing Morris, Lwanda has criticised, with good reason, the ethnocentric fixation with witchcraft and illnesses associated with witchcraft that has been displayed by colonial commentators on Malawian medical culture. This has resulted in an extensive discussion of witchcraft detection and eradication, and “offensive” and “defensive” medicines, and much less discussion of those illnesses understood to be caused by different kinds of moral transgression, by spirits or by “natural” causes. However, Lwanda also stresses the “positive” and “socially constructive” aspects of “sorcery” – as mechanisms of social control. For Lwanda, “witchcraft” is a result of the corruption of taboos.[44]

While Lwanda’s criticism of ethnocentric European accounts is justified, his framework of pre-colonial medical culture also has its own problems. While, on the one hand Lwanda attempts to separate “purely medical” practices from those practices connected to “witchcraft” and criticises the labelling of medicines as “offensive” or “defensive”, on the other he stresses that the concept of *mankhwala* includes “all paraphernalia of witchcraft”. Here, like the more positive early missionary commentators on African medicine, Donald Fraser and T.C. Young, Lwanda cannot escape from the problem of translating the concept of *mankhwala*, a substance which Western analysis is bound to divide into “magical” and “purely medical” or “herbal” components.[45]

However, the problem is, in part, created by a limited and narrow definition of “medicine” as being a substance with therapeutic or prophylactic qualities based on distinct biochemical and pharmaceutical properties. In historiography or anthropology, this can create, as Vaughan has warned, a false dichotomy for analytic purposes. For a social or cultural historian, or an anthropologist, a biochemical analysis of past medicines is not required: it is how medicines were used, what people thought of medicines and the stories that they told about them that are significant.[46]

Thus, “medicine” can be defined according to its social function, not by its content in a scientific analysis of how it “really” works. Within such a flexible definition, the concept of *mankhwala* is less problematic. All *mankhwala* intended or used to prevent or cure illness can be translated as “curative or preventive medicines”. However, in the process of translation, dichotomies are arguably unavoidable. For example, *mankhwala* used to injure or kill others, could be translated as “poisons”, “charms” or “bad medicines”. However, if Morris is correct in his statement that in chiChewa language, there is no concept of

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44 Lwanda 2002, pp. 62-64.

45 Ibid; Cf. Hokkanen 2004. This view resembles the internalist view of the history of Western medicine, which represents a dichotomy between a scientific “core” and social sphere. Cf. Jordanova 1995, p. 368.

46 Vaughan 1994a, pp. 291-295, D.C. Scott provided an useful insight in his *Dictionary:* “Medicine power plays its part in the campfire or *bwalo* stories. Nowhere, however, is there found the thick darkness [superstition] which one is taught to look for...the darkness is no more impenetrable than it is in civilised lands...” Scott 1897, p. 316. The importance of stories, narratives and rhetoric have recently gained increasing attention in the social and cultural history of medicine. See Harley 1999: Hunt 1999; White 2000.

"nature" as such,[47] it could be argued that imposing a Western magical–natural dichotomy would make little sense in a local theory of illness. Judicial, moral, religious, ontological and scientific judgements and assessments are all involved in the classification of substances as "medicine", "poison" or "charm", and the same substance can be assigned all these labels in different social contexts.[48]

Pre-colonial medical pluralism

Lwanda's valuable thesis synthesises the disparate previous studies of pre-colonial Malawian medicine and presents a generally convincing framework and starting point for a historical study of missionary medicine and colonial medical pluralism in the region. However, in addition to the persistent problem of "magical/natural" dichotomies, his work can be, to some extent, criticised for representing too complete a framework of the pre-colonial "comprehensive medical service", or too perfect a "medical system". Arguably, such terms can create an exaggerated picture of pre-colonial nineteenth-century medical culture in Malawi as homogenous, harmonious, all-encompassing and broadly capable of dealing with all health crises. As Feierman notes, there is a case to be made for the existence of pragmatic public health control in pre-colonial Africa, but it is important not to present an entirely harmonious picture.[49]

For his part, Charles Good has argued that the appraisal of the efficacy of the pre-colonial "medico-religious health care systems", and particularly indigenous curative medicine, remains impossible. According to Good's assessment of cultural ecology of disease in the region, pre-colonial Malawians would have frequently faced food shortages and suffered from nutritional deficiencies, notably of protein and iron, and that these deficiencies interacted with diseases such as tropical ulcers, malaria and dysentery. Seasonal hunger was typical between November and February when crops were not yet ripe. Endemic malaria (common in areas below 4,500 feet), water-borne

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47 Morris 1985, p.18. The problem of the English term "charm" is highlighted by the fact that D.C. Scott did not include a single translation for it in his extensive dictionary. Mackenzie wrote about powerful Ngonde medicines against witchcraft, *"which would probably be called charms in Europe; but as the Konde call them medicines, I prefer to use that term"*. Mackenzie 1925, p. 260.

48 Marwick partially addressed the same problem of definition, but adopted a different approach, in his study of sorcery among the Chewa. Marwick 1970, p. 69. Marwick argued that "medicines" is an inadequate translation of *mankhwala* in the discussion of magic, sorcery and witchcraft. "Magic" in his definition is a morally neutral action which "comprises ritual involving the manipulation of material substances believed to have powerful specific properties...and the use of verbal spells or addresses directed towards the influencing of forces, conceived of as impersonal, that are believed to govern the course of events". Magic may be used for a) productive, protective or curative purposes or b) destructive ones. Marwick defined "sorcery" as "applications of destructive magic...that are socially disapproved or deemed illegitimate." As the concern in this study is healing and quests for health, not magic, sorcery or witchcraft, "medicines" is used throughout, while "magic" and "charms" are more problematic terms for this enquiry.

49 Feierman 1985, p. 118.

schistosomiasis (bilharzia), hookworm, other helminths (parasitic worms) and dysentery, along with yaws, leprosy and smallpox, posed major threats to the health of the African populations. Good concludes that in pre-colonial Malawi it was probable that a "large proportion of population was in poor health, either seasonally or perennially"[50], but the matter remains open to speculation.[51] However, Good also stresses that "Despite the endemic high mortality rates, successful reproductive strategies ultimately enabled most societies to transcend the hunger episodes, endemic and epidemic diseases, violence, and anomie that promoted and exploited social weakness and demographic weaknesses."[52]

It is argued here that the culture of indigenous agriculturalists in Malawi contained, in theory, a medical system, or a comprehensive system of public health and a more disparate set of therapeutics. However, it is difficult to say how comprehensive these systems or sets were in practice, how the people regarded them, and how they changed during the course of the nineteenth century. Assuming that the medical culture was dynamic and changing, there were probably important local variations and developments. It is clear that Yao, Swahili and Ngoni invasions brought about important changes, conflicts and co-operation in the field of medicine and healing. Directly or indirectly, changes in politics, religion and socio-economic conditions, relationships and networks all influence health, illness and therapeutics. The invaders overthrew many established political and religious rulers, and in consequence disrupted the system of public health in many localities. Ngoni invasions in particular seem to have caused considerable damage to territorial cults, especially in the north. Cult centres were destroyed and ritual specialists were killed or scattered across the territory. The concentration of people in large stockades, or in confined areas, limited or prevented the available options in cases of migration and isolation due to epidemics or famine. Although the theory that an economic crisis in the second half of the nineteenth century resulted in a general religious crisis is debatable, it is clear that the end of the century saw waves of large-scale

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50 Good 2004, pp. 229-230, 254-259. In the 1890s in the Nkhotakhota area, UMCA missionaries observed that April and May were "unhealthy months", when food scarcity and poor nutrition contributed to the low resistance to disease.

51 Good's primary sources on Malawi are H.H. Johnston's *British Central Africa* (1897), Kerr Cross's *Health in Africa* (1897) and the publications of UMCA missionaries from the 1890s onwards, and the important secondary source of King and King's *The Story of Medicine and Disease in Malawi* (1991). Dr William Scott's memoir of his medical practice in Bandawe in the 1880s and the unpublished early Livingstonia missionary writings do not describe the overall African health conditions as disastrous. The earliest published history of the first six years of Livingstonia stated that in the mission dispensary, "serious cases are not common". *Livingstonia mission...a six years' history and appeal.* Edinburgh 1881. Laws' and Scott's writings suggest that in the late 1870s and early 1880s, the African population seemed to suffer above all from war and the slave trade, and from disease to a lesser extent. This has, of course, to be considered in the context of the early missionaries' own poor health, which was the main priority for the first doctors.

52 Good 2004, p. 256.

witchcraft accusations and increased use of the poison ordeal in the Malawi region.[53]

The distinct social composition of the Ngoni kingdoms arguably fostered a dynamic medical, as well as religious and cultural pluralism. Evidence from Mpezeni's Ngoni in eastern Zambia suggests that the Ngoni adopted the *mwavi* poison ordeal from the indigenous agriculturalists. However, the Ngoni changed the ordeal significantly, transforming it from an individual witchcraft investigation into a process of communal cleansing where the culprit or culprits were identified at public gatherings. The Ngoni religion of the late nineteenth century focused on the ancestral spirits of the paramount chief.[54] However, the relatively pluralistic religious attitude of the Ngoni in times of crisis is well represented by the statement of a Ngoni councillor to Elmslie and Koyi during a drought in 1886. The Ngoni asked the missionaries to pray to their God for rain, and Elmslie asked why the Ngoni would not deal with their problem and with their spirits themselves. A councillor answered:

> We have met many tribes in our wanderings and none of them were without a religion and many of them differed, so we are different from you and we just come to ask that you should try your God since ours have failed us. Each one thinks his own religion best and so we come to you to see if your God will give us rain when you ask him.[55]

The Ngoni conquerors were keen to appropriate medical knowledge and incorporate into their own medical culture medical and spiritual specialists, medicines, and practices from the subjugated peoples. It was typical of the conquerors to attribute negative phenomena, notably illness, to the spirits of their vanquished foes. After they had raided the Chewa shrines, the Ngoni believed that some of their illnesses had been caused by the Chewa spirits, which prompted them to turn to their enemies for cures.[56]

In the north, the Tumbuka were particularly appreciated for their extensive knowledge of medicines, their anti-witchcraft measures and their war medicines. According to J.B.C. Mkandawire, the Tumbuka medical specialists earned respect from the Ngoni chiefs, who regarded them as close friends and

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53 McCracken 2000, pp. 42-45; Feierman 1985; Feierman and Janzen 1992; Schoffeleers 1979; Vail 1979; Vail 1983. Vail has argued that in Northern Ngoniland during the late nineteenth century, Ngoni rule upset the ecological balance by concentrating too many people and cattle into a narrow area around the Kasitu Valley. This marginal land had previously been successfully cultivated by small and sparsely-distributed southern Tumbuka communities who practised a longfallow system of agriculture, where gardens were only cultivated for one or two years at the time, after which the depleted land was left to renew for up to twenty years. By the 1880s, the Ngoni were suffering from food shortages, and raids were increasingly for grain rather than people.

54 Rau 1979, pp. 131-137; Waite 1992, pp. 225-226.

55 Quoted in Elmslie to Cross 8 January 1886. NLS, Acc. 9220 (i), (iv); Ranger 1975a, p. 6. Elmslie's translation may be inaccurate, but it should be noted that in this dialogue, William Koyi (a fluent vernacular speaker) was with Elmslie, giving the account more credibility.

56 Linden 1979, pp. 197-199; Rau 1979, pp. 138-139; Schoffeleers 1979, p. 30. For the widespread *ngoma* - ritual of healing and dance in Southern and Central Africa, see Janzen 1992, van Dijk et. al. (eds.) 2000.

were willing to learn from them. The most renowned specialists largely dealt with witchcraft, but it is probable that as the Ngoni had been travelling over large areas with variable vegetation and different kinds of medicinal plants, they were dependant upon the groups among whom they had settled for knowledge of local medicinal herbs and roots. In Northern Malawi, these were the Tumbuka peoples. Among the Tumbuka, the Phoka people (who avoided Ngoni raids by retreating to mountains) have, to this day, a reputation as people with extensive knowledge of medicines. When the missionaries arrived on the Khondowe plateau, there were renowned and established practitioners in the vicinity.[57]

The Swahili and the Yao also contributed to medical as well as religious pluralism. As Feierman has noted, in the nineteenth and twentieth centuries not only missionary and colonial medicine but also Islamic medicine challenged and influenced indigenous medicine in East Africa.[58] Muslim traders brought new medicines and disseminated new medical knowledge and methods. The traders brought with them Islamic medicines, prophylactics, talismans and Koranic texts, which were sometimes believed to have preventive or curative properties. As such, they could be categorised by Europeans as "charms" while belonging to the broad category of *mankhwala.* Some Muslim traders were believed to be holy men, healers and soothsayers, and Islamic theology was in general more tolerant than Christian theology towards indigenous divination and magic.[59]

Finally, the discussion of pre-colonial medical theory and medical specialisation should be followed by a note of caution about varieties of medical practice, patient–healer relationships or explanations given to illness or healing. In many cases a perfectly coherent system of meanings and social and intellectual contexts can be constructed to explain "why" and "how" a given therapy or medicine "works". However a historian or social scientist should bear in mind that there is a real possibility that many patients or practitioners were not sure, did not know, or even want to know, the fundamental causes of illness or what constituted a medical "system". Following Murray Last, it is important to recognise the possibility of "not-knowing" and prefer the notion of a less fixed, more fluid "medical culture" to an all-encompassing "medical system". This implies a caveat when speaking of medical pluralism, for you can only choose between different medical systems if there are existing systems to

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[57] Mkandawire 1971; Vail 1983, p. 244; Oral testimony, D.C.M., 12 July 2004.

[58] Feierman 1985, pp. 118-120; Feierman 1990, p. 104.

[59] Liweve 1982; Henry Drummond described in the 1880s how Arab traders always carried seeds with them to plant in the areas they settled in. It is probable that medicinal plants were also transplanted in this way. Drummond 1888, p. 71. In Mponda II's stockade in the late 1880s, there were *Alibadiri* "charms", with verses of the Koran wrapped up in leather thongs. In Linden's words, the town was "an astonishing hotch-potch of religious ideas and practices" with Muslim, indigenous African and Christian elements, and there was constant demand for all kinds of medicine and therapy. Linden 1974, pp. 25-32.

choose between.[60] However, it can be argued that at an individual level, a patient can choose between healers without necessarily knowing of or being interested in the medical theories involved.

The problem of historical source criticism must also be addressed. Although Lwanda and Morris credibly criticise colonial writers, the fact remains that almost all written sources describing African medicine from nineteenth-century Malawi are colonial sources, and suffer to a greater or lesser extent from ethnocentrism, over-reliance on the magical–natural dichotomy and have limited credibility as evidence. The problem is highlighted by the fact that critical modern scholars who stress the "positive" and "effective" aspects of pre-colonial medical culture, in addition to their valuable consultation of oral sources, have to quote the same much criticised colonial writers when they occasionally approved of some African medical methods.[61]

As Morris notes, modern Malawian healers have also been influenced by Western medical conceptions for over a hundred years. As a result, some disease conceptions have undoubtedly changed: for example, *malungo* has come to be identified as "malaria" while its earlier meaning referred to general feverish conditions and focused on the specific symptom of weak joints. Medical theory, practice and the entire medical culture have also undoubtedly changed significantly from the times of early colonial contact. Indigenous medicine has integrated, as Good has pointed out, new ideas and practices, including biomedical procedures and symbols. For his part, Feierman has emphasised that in general, the colonial experience in Africa transformed healing in important ways, and the emerging medical culture was, in comparison with pre-colonial medicine, less concerned with public health and more "a collection of treatments for individual conditions or, at most, for afflictions which affected localized groups".[62] It is therefore difficult and dangerous for a historian to attempt to draw firm conclusions from contemporary medical anthropology. It should be noted that while pre-colonial and early colonial Malawi may, for analytical purposes, be discussed as one medical culture, there were (and are) important local variations in conceptions and terminology of illness and disease, as well as in therapeutic practices.

2.2 Disease and imperialism in South-Central Africa

Until the late nineteenth century, the African interior had been largely beyond European reach. Disease was a crucial factor in this: in tropical Africa, the very high mortality rates among European sailors, soldiers and explorers had made

60 Last 1992; Vaughan 1994 a, p. 291. For example, according to Morris's modern study, the Chewa do not normally search for the underlying aetiology for many illnesses at all. Morris 1985, pp. 33-34.

61 Lwanda 2002.

62 Good 2004, p. 260; Feierman 1985, p. 120. Morris 1985, pp. 32-34. *"Malungo"* was translated as "fever" in Laws' English–Nyanja dictionary in 1894. Laws 1894.

colonial conquest virtually impossible during the early nineteenth century. The most deadly diseases were "African fevers". Only during the second half of the nineteenth century did the mortality rate of the Europeans in the interior decrease to a level that made imperial occupation feasible. As has been argued elsewhere, the three innovations which made the late nineteenth-century "Scramble for Africa" possible were the steam engine, the Maxim gun and quinine.[63]

In preventive medicine and public health, European colonialists in the nineteenth century were particularly concerned with medical topography. Altitude, temperature, rainfall, winds and soils were all considered crucial factors when determining the healthiness of any location. Heat and putrefaction signified disease, and higher and cooler locations were commonly believed to be safer than low-lying areas. From the early nineteenth century onwards, the British in India had established "hill stations" as health retreats. This policy was also later adopted in many parts of Africa.[64]

Malaria in Victorian medicine

In their general explanations of fever, the Victorians stressed the importance of local conditions and factors. In this respect, they were continuing the tradition of the Hippocratic physicians who had connected fevers to the weather, seasons and sites.[65] As Michael Worboys has illustrated, before the 1890s, Western doctors treated "diseases in the tropics", practising ordinary medicine in extraordinary conditions: the notion of "tropical diseases" and the distinct specialisation of tropical medicine was only established during the 1890s.[66]

In Worboys' words, "Any discussion of malaria in the nineteenth century has to begin with the differentiation of malaria as a generic term for miasmas and miasmatic diseases and its subsequent restriction to a specific, febrile disease."[67] This change occurred during the second half of the nineteenth

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63 Cook 1994, p, 33; Curtin 1989, pp. 62-68, 132-140, 159-161; Headrick 1981. Quinine sulphate was isolated from cinchona bark in 1820, and in the early 1840s, the second Niger Expedition used quinine as a prophylaxis, with a subsequent mortality rate of "only" twenty-nine per cent.

64 Collingham 2001, pp. 86-87; Curtin 1992, pp. 235-236.

65 Wilson 1993, pp. 384-400. In treatment, the general use of stimulants, such as alcohol and calomel (mercurious chloride) had already been established in the eighteenth century.

66 Worboys 1993, pp. 512-520.

67 Worboys 1996, p. 186. Present-day Western medicine divides malarial fevers into four different main categories, caused by different types of *Plasmodium* parasites, entering the blood through mosquito bites. Quartan malaria, caused by *plasmodium malariae*, is a milder disease, beginning with a chill followed by high fever, nausea and vomiting. After about six hours, the fever attack passes. Subsequent attacks follow every fourth day, and the disease may recur for several months if untreated. *Plasmodium falciparum* causes much more dangerous malignant tertian malaria, resulting in more prolonged and variable fever, which may be continuous, intermittent or remittent, with a typical interval between attacks of twelve to twenty-four hours. The patient suffers from severe anaemia and bilious vomiting, the spleen and liver become enlarged and the patient is jaundiced. In a complicated case, this

century, but like many other diseases, the causation of malaria remained a controversial topic during the 1860s and 1870s among the British medical authorities. In the latter half of the century, a "general differentiation and re-designation of zymotic diseases into specific syndromes on grounds of symptomology, pathological anatomy and eventually aetiology", emerged, but as late as 1883 the editor of *Parke's Manual of Practical Hygiene*, an influential medical reference book, used the term "malaria" in the old, miasmatic sense. What would in retrospect be called malaria was often classified as intermittent, remittent or paroxysmal fever. Fever was measured, timed and classified with the help of thermometers and clocks. Malaria was often discussed as the excitatory cause of disease, "quite independently of clinical and pathological accounts of its effects in the different fevers."[68]

Before the emergence of germ theories, remittent and intermittent fevers were seen either as zymotic diseases produced by malarious (bad air) conditions or, according to the "chill theory", as "febrile syndromes produced by the effect of heat on the constitution". Fevers in tropical areas were, in principle, viewed to be not dissimilar to fevers in temperate zones. However, it was believed that these fevers became more common and dangerous in the tropics. Victorian medical authorities were divided over whether this increased frequency was due to greater heat or humidity, lack of civilization and sanitary reform in particular, or "some combination of these".[69]

The "chill theory" was flexible. It could be combined with miasmatic theories so that an external agent would first cause internal changes within the body, and later, sudden temperature changes would produce subsequent attacks. Poison and chill theories both contributed to the strategies employed to prevent or fight the disease. Colonial settlements were to be built away from malarious poisons or from extremes of temperature and individuals themselves should take precautions to avoid exposure to poison and temperature. Quinine was to be used as both a prophylaxis and a cure, "acting either as an antidote to the poison or the febrifuge."[70]

Quinine and pioneer exploration in East Africa

A small group of Western explorers charted the East and Central African interior between the 1850s and 1870s, paving the way for further missionary, commercial and imperial endeavours. The great explorers became renowned heroes of their day, and provided their European audience with the first

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disease can develop into "blackwater fever" marked by completely black urine, resulting from a massive break-up of red blood corpuscles. Honigsbaum 2001, pp. 20-21; Wilson 1993, pp. 384-388.

68 Worboys 1996, p. 186; Curtin 1964, pp. 71-75. In the early nineteenth century, fevers were generally classed as 1) remittent, with fever occurring at irregular intervals; 2) intermittent, with fever occurring at regular intervals, and which could be further classed as quotidian, tertian, etc.; 3) continuous fever.

69 Worboys 1996, pp. 186-187.

70 Ibid., pp. 187-188.

descriptions of the Central African interior, its geography, topography, flora, fauna and ethnography. They "discovered" the great lakes and waterways, providing information for the establishment of steam-powered inland transport. Furthermore, they reported the horrors of the slave trade, as well as produced exotic images of African "savages". As Brantlinger has noted, somewhat paradoxically, the more the African interior was "revealed" to the European audience, the "darker" Africa and Africans became in European minds.[71]

For the British, David Livingstone was the man who "found" the Malawi region. In 1856 he travelled down the Zambezi and in 1859 reached Lake Malawi, which he named Lake Nyassa. In fact, the Portuguese knew about the lake region long before Livingstone's travels. However, Portugal initially lacked the resources and the interest to occupy the territories to the north of their small settlements on the Zambezi. Livingstone's famous journeys and his programmes to foster British settlement and trade in the interior disturbed the Portuguese, who foresaw this as the beginning of British territorial claims in the area. Colonial competition between the British and the Portuguese in the region did not intensify until the late 1880s when the old revived Portuguese dream of a colony extending from Angola to Mozambique clashed with the new British vision of an African empire extending from Cairo to the Cape.[72]

Livingstone became aware of quinine and its prophylactic properties in the 1840s, and used it during his travels in the interior. He regarded "the fever" to be the greatest obstacle to evangelisation of Africa, and the study of it became part of his major journeys in 1853–56 (transcontinental), 1858–63 (the Zambezi expedition) and his last journey of 1866–73. "The fever" was a prominent issue especially during the Zambezi expedition, which suffered heavily from illness, despite the regular use of quinine. Prior to this expedition, Livingstone had deliberately played down the dangerousness of "the fever", and although the death rate of the expedition, three out of eighteen, was relatively low for the time, the casualties, including Livingstone's wife, were a heavy blow to the explorer and his plans for the introduction of commerce and Christianity in the region.[73]

Livingstone made medical observations throughout his travels, investigating local African medicines and making notes on various diseases. Among his African patients, Livingstone largely practised minor surgery, ophthalmology and obstetrics, believing that in these fields the superiority of Western medicine and surgery was most apparent. Following the miasmata

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71 Brantlinger 1988, pp. 173-198; Oliver 1952, pp. 26-33.

72 Jeal 1973, pp. 215-219; Linden 1974, pp. 2-6; Pachai 1973, pp. 61-70; Schoffeleers 1992, pp. 119-126, 133-136. The Portuguese had first established colonies and missions on the coast of Mozambique during the sixteenth century, and advanced up the Zambezi by the early seventeenth century. By the mid-nineteenth century, Portuguese explorers had travelled from Angola to Mozambique and located the Shire Highlands and the lake regions.

73 Cook 1994, p. 33-38; Gelfand 1973, pp. 186-188; Jeal 1973. Apart from fever, the pioneer explorers suffered heavily from intestinal infections, causing diarrhoea and dysentery.

theory, Livingstone distinguished different types of fever in different regions, due to variations in soil type. His standard prophylactic quinine dose was two to three grains per day. In his treatment of malaria, he used a mixture of quinine and purgative and developed a number of different variations. The best-known of these preparations was "The Livingstone Rouser", which was adapted and mass-produced by Burroughs Wellcome, until 1930.[74]

The use of quinine contributed significantly to the success of European exploration, the establishment of pioneer outposts, and the eventual colonial conquest of the African interior. However, the importance of quinine should not be overstated. It was initially an expensive treatment, not universally accepted until the late nineteenth century, and there was considerable debate among doctors over the correct dosage and efficiency of quinine as a prophylaxis or a cure. In addition, it had an unpleasant, bitter taste and was difficult to swallow. Despite the development of quinine, mortality rates remained very high among the pioneer Europeans in Central Africa until the end of the century.[75]

Commerce, Christianity and imperialism in Central Africa

Livingstone believed, in 1857, that the Zambezi would provide a navigable waterway into the interior and form the basis of transport for "legitimate commerce". He actively propagated this vision in Britain, and attracted considerable initial interest. Two years later he found that although the Zambezi was not the highway he had hoped for, its tributary the Shire, connected to Lake Malawi, provided the best available waterway into the interior, notwithstanding the formidable cataracts and other hindrances on the river. He visited the Shire Highlands and the lake in 1859 and 1861, and became convinced that the region, with its dense population and promising trade goods of ivory and cotton, would be the ideal location for missionary, commercial and agricultural activity.[76]

A group of English High Churchmen, who formed the Universities' Mission to Central Africa (UMCA), were the first to respond to Livingstone's appeal. The pioneer UMCA party arrived at the Zambezi in 1861, but the

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74 Cook 1994, pp. 35-38; Porter 1997, pp. 468-471. Livingstone's daily dosage of quinine has been regarded as too low from a modern point of view. The rationale for the purgative was to evacuate the bile from the gall bladder. "The Livingstone Rouser" (or "The Livingstone Pill") was made from three or four grains of jalop, three or four grains of calomel, an equal number of quinine, one or two drops of tincture of cardamoms, and ginger or cinnamon as the bolus.

75 Cairns 1965, p. 18; Curtin 1989, pp. 62-65. Missionaries suffered heavily, and Cairns has argued that the pioneer missionaries' mentality must have "contained a set of explanations which muted the impact of failure, disaster and death, and...often changed them into divine portents of future success." Almost a quarter of Livingstonia's agents appointed between 1875 and 1900 died of illness. McCracken 2000, p. 84. The Catholic White Fathers in Africa lost 46 of their 175 priests ordained between 1868 and 1878, most due to disease, before 1889. Linden 1974, p. 16.

76 McCracken 2000, pp. 47-49, Jeal 1973.

mission ended in disaster after only three years. The missionaries settled in Magomero in the Shire valley and become involved in local fighting between the Yao and the Mang'anja, were plagued by disease, and their settlement was hit by the worst famine recorded in the history of Malawi. Bishop Mackenzie, the leader of the mission, and three other missionaries died, and others were invalided home. Livingstone's Zambezi Expedition also suffered losses, and the UMCA disaster and these Expedition failures seriously damaged Livingstone's reputation. James Stewart, a Scottish Free Church student of medicine and theology, had planned another industrial mission to Central Africa, but his disappointing visit to the Shire Highlands, now troubled by famine and war, led him to abandon the scheme by 1863. The Zambezi was not as navigable as Livingstone had first believed, and the climate of the Shire valley was generally condemned as being unhealthy for Europeans. The following year, the UMCA base was moved to Zanzibar.[77]

By the early 1870s, however, conditions were more favourable for new projects in Central Africa. Livingstone's death in 1873 and his public burial in Westminster Abbey the following year provided a significant symbolic image of martyrdom, and justification for the new Protestant missionary movement in Africa, but it was only one contributing factor. There was growing commercial, political and humanitarian interest in Africa, which was encouraged by ongoing exploration and boosted by improved technology and transport connections. By the end of the 1860s philanthropic attention had shifted from the trans-Atlantic slave trade to East Africa. The Sultan of Zanzibar signed an anti-slavery treaty, in 1873, which formally prohibited the slave trade in his dominions as well as the export of slaves from the East Coast. The Suez Canal, opened in 1869, made a regular steamship service along the coast possible. Discoveries and reports of diamonds and gold in Southern Africa prompted unprecedented mining and commercial interest in the continent, attracting prospectors and concession seekers to the interior. King Leopold II of Belgium formed the African International Association, in 1876, as a vehicle for his scheme to establish a colony in Central Africa. The growing interest in Africa and imperial competition culminated in the Berlin Conference of 1885 and the subsequent carving up of African colonies by the European powers in the "Scramble for Africa".[78]

Before and during this period of formal imperial interest and commercial enterprises, various Protestant and Catholic missions established bases and spheres of interest in East and Central Africa. Between 1875 and 1885, the British Church Missionary Society (CMS), London Missionary Society (LMS), UMCA, Church of Scotland mission in Blantyre and Free Church of Scotland

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77 Cairns 1965, p. 9; Iliffe 1984, pp. 251-252; McCracken 2000, pp. 50-59; Jeal 1973, Oliver 1952, pp. 9-15; Porter 2004, pp. 185-186. A disillusioned Stewart threw Livingstone's *Missionary Travels* into the Zambezi and after graduation moved to the South African mission field, where he became the Principal of the Free Church's Lovedale Institution.

78 Cairns 1965, pp. 9-10; Fry 2001, 149-151; McCracken 2000, pp. 56-62; Oliver 1952, pp. 18-19; Pachai 1973, pp. 70-72; Pakenham 1991.

mission of Livingstonia were all established on the mainland, together with the Catholic White Fathers and Holy Ghost Fathers. The Livingstonia Mission on the shores of Lake Malawi was the first of these missions, founded in 1875 and followed by the Blantyre Mission of the Established Church of Scotland in the Shire Highlands the next year. The Scottish missions were followed to the Lake Malawi region by the African Lakes Company (ALC), a commercial enterprise closely connected to Livingstonia which aimed to introduce "legitimate" trade to substitute the slave trade. Alongside the missionaries, individual European hunters and traders started to arrive in the lake region in the 1870s, and the first European coffee planter, a former Blantyre missionary, established his enterprise in 1881. The UMCA returned to the lake in 1885 and settled at a new base on Likoma Island near the eastern shore, and were followed in 1889 by the Dutch Reformed Church (DRC) Mission from Southern Africa, a group with close connections to Livingstonia.[79]

The missions provided intelligence and impetus for imperial interventions against the slave trade, and the relations between missionaries and the Swahili traders deteriorated during the 1880s. At the northern end of Lake Malawi, the ALC, supported by the Livingstonia missionaries, organised a small military expedition to fight the Swahili leader Mlozi's forces in the "Arab War" of 1888–89. This conflict, which ended in stalemate, was one incident that attracted much interest in Britain, and was part of the chain of events which eventually led to the British annexation of the Malawi region as the British Central Africa Protectorate. The Scottish missions, the ALC and their supporters in Britain also drew attention to the increasing Portuguese influence on the Shire and Portugal's aspirations to annexe the highlands. The Portuguese, who controlled the vital transport lines on the Zambezi and the Shire, were accused of being corrupt, lax in their attempts to tackle slavery, fostering the liquor trade and generally being unworthy of colonising the Shire Highlands. The official British foreign policy was sympathetic to the Scottish missions and the ALC, but initially showed little interest in investing money in the establishment of a British protectorate in the region.

In 1889, Cecil Rhodes, who was seeking a charter for his British South Africa Company for a massive annexation of territory in South-Central Africa, offered £10,000 a year to fund the administration of the British Protectorate in the lake region as part of his ambitious schemes for British imperial and commercial expansion in Southern and East Africa. This made it possible for the British Government to take action without initially committing any taxpayers' money to the project, and to avoid political debate in parliament. Harry Johnston was sent by the British Government to Lisbon to negotiate with the Portuguese. During the lengthy negotiations, Lord Salisbury, the Prime Minister, mustered the support of missionary opinion at home, and in particular, the Scottish churches, to thwart Portuguese aspirations for the Shire Highlands. A British protectorate over the highlands was declared in 1889 and through a series of treaties and small wars over subsequent years the British

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[79] McCracken 2000, pp. 74-76; Oliver 1952; Pachai 1973, pp. 85-88, 97.

Central Africa (BCA) Protectorate was founded, initially funded by Rhodes and administered by Johnston. As Oliver has noted, the missionary occupation of the region had "provided both the historical justification and the immediate pretext for the British annexation". African leaders resisting British rule or taxation were crushed by military force and by 1898 only Northern Ngoniland remained as a major independent African political unit in the Malawi region.[80]

Rhodes supported the BCA Protectorate financially until 1895. In 1893, his company bought the ALC with its considerable land holdings in the Protectorate, and Rhodes wanted the BSAC to be given preferential treatment over land and mineral concessions in the region. However, missionaries (especially those from Blantyre) together with European planters from the Protectorate protested strongly against what they saw as the transformation of the country into another Rhodesia, and Johnston's administration restricted the influence of the BSAC, although the company owned one fifth of the land in the Protectorate and remained a powerful influence in the country. In 1893 European missionaries, traders and planters also owned about one fifth of the land in the Protectorate, while Africans held the remaining two fifths. There were over three hundred Europeans living in the Protectorate by 1896. Most of the Europeans settled in the southern parts of the country, in particular in the Shire Highlands, where the government centre had been established at Zomba. Local administration centred on *bomas*, district administrative headquarters, twelve of which had been set up by 1895.[81]

Following the imperial conquest, new missions were established in the Protectorate, challenging the dominance of the two strong Scottish missions. In 1892, an English former businessman, Joseph Booth, founded the Zambezi Industrial Mission (ZIM) at Blantyre. Five other small missions followed by 1900, most of which had been associated with Booth at some point. Two Catholic missions, the Montfort Marist Fathers and the White Fathers, were established in the Protectorate in 1901–02. By the First World War, Nyasaland was, in Linden's words, "one of the most heavily missionized countries in Central Africa", with almost a quarter of the eight hundred Europeans in the Protectorate involved in missionary work.[82]

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80 Fry 2001, pp. 167-168; Linden 1974, pp. 13-17. McCracken 2000, pp. 147-149, 197-199; Murray 1932; Oliver 1952, pp. 109-128; Porter 2004, pp. 268-274. For the British, the sexual liaisons of the Portuguese with African women were especially abhorrent, as Good points out. Good 2004, p. 127. The Catholicism of the Portuguese was also an obvious issue of concern for the Scottish Protestants. For their part, the Portuguese wished to see Catholic missions established in the Shire Highlands to counteract the Protestant influence and the British expansion. For the short-lived White Fathers' mission in Yaoland, see Linden 1974, pp. 13-35. The British Protectorate was first called the Nyasaland Districts Protectorate (1891), then British Central Africa (1893) and from 1907 until independence in 1964, the Nyasaland Protectorate. Good 2004, p. 58.

81 Baker 1972, p. 339; Good 2004, p. 65; Pachai 1973, pp. 82-86, 101. The final fifth of the land in the Protectorate belonged to the British Government.

82 Linden 1974, pp. 42 ff, 74; McCracken 2000, pp. 216-217, 244-258. Furthermore, the Watchtower movement, based on teachings of Charles Taze Russell, and Sabbatarianism, as advocated by Seventh Day Baptists, were spreading in the Malawi region as independent African religious movements. Both originated in the United States and spread to Malawi via South Africa by migrant workers. Booth, who became

The establishment of British colonial rule and the integration of the Protectorate into the Empire wrought massive changes upon local economies. Cultivated produce, first coffee, and then, in the early 1900s, tobacco and cotton replaced gathered produce such as ivory and wild rubber as the main items of export. A monetary economy was established and English coins were introduced into circulation in 1892. Taxation, and in particular the hut tax, was imposed by force. Some African cultivators successfully managed to transform themselves into cash crop farmers, but for many, wage labour, established by the missionaries and the ALC before the colonial conquest, was the only way to meet the new economic demands being made upon them. In the north, by the turn of the century, large numbers of the Tonga, the Tumbuka and the Ngoni had become migrant labourers, with the majority travelling to the south to work in European plantations in the Shire Highlands and to the mines of Rhodesia and South Africa.[83] The first tax collection in Northern Ngoniland in 1906 disconcerted the people, while the next collection, the following year, provoked a tax rebellion followed by colonial punishments: burning of villages, arrests and beatings. The result was large-scale migration to the Rhodesias to work as waged labourers. In 1912, the annual hut tax was increased from six to eight shillings, which cause widespread discontent. Coinciding with a severe famine in many districts, this tax raise was a severe blow to African material well-being. In Northern Ngoniland, as Vail has argued, "colonialism did not ease the poverty of the 1880s and 1890s; rather, it set the seal upon it."[84]

The Protestant missions as employers and educators in Malawi contributed to the development of the labour migrant system, which developed under the tax and labour policies of the colonial and imperial administration and authorities and the increasing demand for labour in Southern Africa. In Ian Linden's words, for most Malawian villagers in the early twentieth century, changes in daily life "were largely the product of labour migration rather than mission interference". Labour migration connected the Malawi region to the colonial centres of Southern Africa, particularly mines and towns. Labour networks enabled the movement of people, materials and money, together with cultural elements, ideas, movements and organisations. Through labour connections, new religious movements such as the Watchtower as well as political ideas of trade unionism and socialism, entered South-Central Africa. Conversely, ideas of witchcraft eradication and political organisation, for example, were disseminated beyond Malawi by Malawian migrant workers.[85]

famous for his radical demands for African independence from 1897 onwards, was involved in both movements during his colourful career. John Chilembwe, a Malawian associate of Booth, studied in the United States in the late 1890s and early 1900s, and upon returning to Malawi founded his own Providence Industrial Mission (PIM), and become an important independent African churchman. For the careers of Booth and Chilembwe, see Langworthy 1996; Shepperson and Price 1958.

83 Good 2004, p. 65; Krishnamurthy 1972, pp. 392-397; McCracken 2000, pp. 150-151; Pachai 1973, p. 83.

84 Linden 1974, pp. 78-79; Vail 1983, pp. 254-256.

85 Linden 1974, p. 207, quoted in McCracken 2000, p. 342; McCracken 2000, pp. 307, 342-343.

Eventually, the majority of the Livingstonia Mission's sphere of operations became part of the Northern Province of the British Central Africa Protectorate, which was peacefully extended to Northern Ngoniland in 1904, with missionaries acting as intermediaries in the expansion. The Protectorate was renamed the Nyasaland Protectorate in 1907. In the Northern Province, the number of Europeans remained very small. There were only five administrative outposts north of Kasungu in 1905. It should also be noted that at the turn of the century the mission expanded westwards into the Northern Rhodesian territory annexed and administered by the BSAC. There the mission established major stations in Mwenzo, where the majority of population were Namwanga, and in Chinsali among the Bemba.[86]

Colonialism and public health

Pre-colonial coastal trade, Swahili, Yao and Ngoni invasions, the British imperial conquest and the establishment of a colonial economy in the Malawi region placed considerable strain upon the pre-colonial medical and religious culture. Increased trade and migrant labour networks spread both old diseases such as smallpox or syphilis and new or previously rare human and animal diseases such as tick-borne relapsing fever, tuberculosis, rinderpest, plague and human trypanosomiasis (sleeping sickness). Devastating epidemics such as rinderpest, smallpox, and influenza were particularly challenging for the indigenous medical specialists and public health authorities. The overthrow of many political and religious authorities had further disrupted the public health systems. In addition, the authority of indigenous diviners and healers was challenged by the missionaries and colonial conquerors. As the Protectorate became a labour reserve for the imperial capitalist economy in the early twentieth century, the local agricultural economies suffered. The absence of men in many areas also contributed to a decrease in local food production.[87]

Particularly devastating for the cattle-rearing pastoral Ngoni and the Ngonde was the rinderpest epidemic, which in 1893 decimated their herds. In the late 1890s and early 1900s, in the peaceful conditions that followed the imposition of British rule, the Tonga and the Tumbuka populations dispersed from their stockades and remote villages. While the new mobility and settlement patterns brought some health benefits, they also contributed to a change in the ecosystem which became more hospitable to animal diseases. As the colonial government imposed restrictions on African possession of firearms, the game population increased. This, in turn, contributed to the spread of the tsetse fly and both human and animal trypanosomiasis. In the 1910s, sleeping sickness fears prompted the colonial authorities to cordon off large areas along

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86 Cook 1975; McCracken 2000, pp. 147, 212.

87 On health effects of the migrant labour system, see Good 2004, pp. 191-195; on diseases, pp. 230-253; Waite 1992, pp. 228-230. Also see Feierman 1985; Kuhanen 2005.

the Nyasaland–Rhodesia border.[88] During the 1910s and 1920s, colonial public health policies in Nyasaland imposed further limitations upon African mobility.

The First World War, and the devastating influenza epidemic which followed it, contributed significantly to a worsening of health and general social and economic conditions in the Northern Malawi region. Thousands of Africans contracted diseases or died while in military service, and influenza killed thousands more in the villages. The price of cloth and other commodities soared while local wages remained static and employment opportunities became more limited. In Nyasaland as well as Northern Rhodesia, the tax rate was doubled after the war. Where no cash crops were grown, standards of living decreased markedly with adverse effects on nutrition and health. In northern Nyasaland, severe famine caused many deaths in 1923.[89]

In his study of mortality among young Malawian men in colonial microenvironments (particularly in the missions and the mines between 1897 and 1927) Bruce Fetter has shown that mortality rates rose abruptly between 1906 and the early 1920s, with some improvement in the mid-twenties. Fetter has argued that for the northern Malawians, the most salubrious living environments were actually found in their own villages, noting that of the "colonial microenvironments", the Overtoun Institution of Livingstonia after about 1904 seems to have been comparatively healthy. By contrast the "risk of death increased perceptibly in areas where people from broad areas were exposed to each other's diseases" particularly in the mines of South Africa, Southern Rhodesia and the Belgian Congo. In these circumstances the imposition of the hut tax across Northern Malawi by 1906, created a situation in which "acquiring European currency meant increased exposure to disease", and often the best alternative was to work for the local mission thus avoiding the dangers of labour migration.[90] This option, however, was available to only relatively few people. It could be argued that mission education and access to higher salaries "increased" health through improved standards of living, nutrition and diet, and better access to Western medicine. However, the Western medical services available even for the African elites remained limited.

Worboys has noted that tropical medicine, a distinct speciality of Western medicine, developed from the 1890s in response to the needs of imperial medical practice. It was largely concerned with parasitic infections such as malaria, yellow fever and sleeping sickness. While tropical medicine concentrated on parasitic infections and especially on the protection of European colonialists, from a modern point of view many of the so-called "tropical diseases" are actually diseases of poverty, malnutrition and insanitary conditions, and are inseparable from general environmental, economic and social conditions. While the colonial conquest caused radical changes in these general conditions and directly or indirectly had a negative impact upon the

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88 McCracken 2000, pp. 152-153.

89 Ibid., p. 310; Vail and White 1991, p. 241; Chisholm to Ashcroft 11 January 1920. NLS, MS. 7885, 1. During the war, 169,000 African carriers were enlisted, many by force, into the Nyasaland Field Force. Good 2004, p. 334.

90 Fetter 1989.

health of indigenous populations, the specialised tropical medicine of the colonialists tended to take a very narrow, medicalised view of the situation.[91] Generally, it has been agreed that colonial public health initiatives in East-Central Africa developed slowly according to the interests of the colonial economy, in order to secure African workers' productivity. From the 1920s the colonial public health programmes included medical examination of workers, control of disease vectors, maternal and infant care, urban sanitation and health education. In Waite's words, "These programs were not always successful, not even widespread. They received only minor portions of colonial budgets, with the funds decreasing over time."[92]

In early twentieth-century Nyasaland Protectorate, the colonial administration had very limited resources available for the provision of health and medical services to the African population. Missions provided almost all of the medical services for Africans before the First World War, and colonial medical services were established gradually during the interwar period. The number of cases treated by government medical services increased from 19,000 in 1921 to 729,000 in 1937, but vast majority of these were treated in the southern part of the country. The funds available were consistently meagre.[93] The few colonial medical officers concentrated their efforts on providing medical aid to Europeans and government employees, and to conduct public health campaigns against epidemics, including smallpox, sleeping sickness, plague and influenza. In the Northern Province before the First World War, government doctors were an occasional presence and there were no African hospitals. By 1920, no medical officer had been stationed within ten days march of Mzimba, where there was a small dispensary but no doctor. The first small government hospitals in the north were established in the 1920s. In the large Livingstonia sphere of operations, therefore, missionary medicine (mostly practised by Livingstonia agents) enjoyed an almost complete monopoly over the provision of Western medicine to African population during this period.[94]

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91 Worboys 1993, pp. 512-520.

92 Waite 1992, p. 228.

93 Good 2004, pp. 332-337; Furthermore, by the 1930s, a significant share of the Protectorate's limited revenues were spent on unproductive railway ventures in Mozambique. McCracken 2000, p. 283, quoting Vail 1975; Baker 1976, pp. 296-311; In 1919, the Medical Department's budget was about one thirteenth of the total government expenditure, by 1929 about one eleventh. In 1927, the medical staff of the Protectorate Medical Department consisted of 14 medical officers, 8 nurses, 9 sub-assistant surgeons, 3 African hospital assistants, 150 dispensers and probationers, 36 vaccinators, 18 sanitary and plague inspectors, 6 clerks, 130 hospital attendants and servants, and about 240 sanitary labourers. Nyasaland Annual Medical Report for 1927; MNA S1/1005/28. Salaries and wages accounted for almost two thirds of the medical expenditure, which rose from £20,000 in 1921 to £53,000 in 1938.

94 Mombera District Annual Report for 1919/1920. MNA S1/1140/19. Both the UMCA on Likoma Island and the Blantyre Mission had extensive medical practices in the early 1900s, but the missions neighbouring Livingstonia, the DRC and the German missions, had more modest medical resources and personnel. The Catholic missionaries in Southern and Central Malawi also practised medicine in the early twentieth century. Linden 1974, pp. 60, 70.

2.3 Livingstonia Mission and its sphere of operations

In 1874, James Stewart, by now in charge of the Free Church's Lovedale Institution in South Africa, proposed that as memorial to Livingstone, an educational as well as industrial missionary institution should be established on the shores of Lake Malawi. Stewart managed to persuade a group of wealthy Glasgow businessmen to back his scheme; Livingstonia was from its inception notably independent from the Free Church Foreign Mission authorities who sanctioned its creation and who were nominally in charge of the mission. Until the First World War, the mission was in practice run by a Sub-Committee dominated by its principal financial backers.[95] In 1878, the First Convener of the Committee, James Stevenson, established the African Lakes Company, a commercial enterprise run by Fred and John Moir. The directors and a majority of shareholders were also members of the Livingstonia Committee. Thus, Livingstonia and the ALC, both ventures crucially based on joint steamboat transportation on the lake, had very close links in Scotland as well as within Malawi. The artisans employed by the mission and the company could be transferred from one employer to the other and many former missionaries became ALC agents.[96]

The joint Livingstonia–ALC project was essentially an attempt to realise Livingstone's plans of evangelisation, "legitimate" commerce and wide-ranging socio-economic reform in Africa. Artisans (carpenters, gardeners, engineers, seamen, joiners and weavers) played a particularly important role in this scheme. The first Livingstonia party consisted of naval officer E.D. Young (who had previously visited the region), a medical officer and ordained missionary, Robert Laws, and five artisans. The mission leaders and heads of stations, after Young, were doctors and ordained ministers. As McCracken has noted, Livingstonia during this period was a truly "industrial mission" in line with the early plans of Livingstone and Stewart.[97] According to Oliver, life before and after conversion, in all its social and economic aspects, were of great importance to both Catholics and Presbyterians. In the Presbyterian tradition, economic improvement and social and moral reform were essential to the gradual creation and growth of the Christian "character". In contrast, material and economic incentives were generally viewed with more suspicion by the English and the Germans, who stressed conversion, momentary "rebirth" or "change of heart", and who preferred to use ordained clergymen as their agents.[98]

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95 Fry 2001, p. 166; McCracken 2000, pp. 59-63, 148-151.

96 McCracken 2000, pp. 74-76, 110-111; Oliver 1952, pp. 35-38. The first Livingstonia, later ALC steamer, the *Ilala,* was possibly the first steamboat on an African lake. Good 2004, p. 62.

97 McCracken 2000, pp. 63-64. Of the thirty-one Europeans appointed to Livingstonia between 1875 and 1885, sixteen were classed as artisans and six others were primarily from "technical occupations".

98 Oliver 1952, pp. 23-26; McCracken 2000, pp. 218-219.

Pioneer settlement and early expansion, 1875-1894

The Livingstonia Mission was founded at the south end of the lake in October 1875 at Cape Maclear, which remained its base until 1881. The first years of the mission were occupied with building a settlement, establishing relationships with African leaders and the general population, learning the vernacular languages, establishing a school and exploring the region. During this period, the leadership of Livingstonia passed from Young to Stewart, who had arrived with the second party in 1876, and then to Laws in December 1877. Laws remained in charge for fifty years, and became a legendary missionary leader in his lifetime. Prodigious in his work habits, he maintained the official correspondence and book-keeping of the mission while learning and translating vernacular languages, teaching in the mission school, preaching and practising medicine among other pioneer missionary tasks. Laws led mission diplomacy and as McCracken has pointed out, few decisions of importance within the mission were taken without him.[99]

At Cape Maclear, the missionaries attempted to establish a Christian colony with the aims of evangelisation, education and commercial as well as industrial reform. They attracted African settlers, who provided the necessary workforce for the construction of the station and cultivation of the land. The objective was to create an "institution" where Africans would remodel their lives after the example of European industry, and be largely separated from indigenous society, particularly from indigenous religious institutions. The mission attracted its first African settlers, from those without a strong position in society – including orphans, refugees and former slaves – but also disappointed headmen who sought the protection of the mission. Consequently, the missionaries faced the problems of political, juridical, and social control of their dependants. The African settlers were provided with food supplies until they could cultivate their own crops and in return they worked for the missionaries. The missionaries in both Livingstonia and Blantyre acted as temporal authorities, punishing offenders with fines, imprisonment, expulsion, or flogging.[100]

McCracken has provided a detailed account of the failure of the mission at the south end of the lake to achieve its main objectives of conversion and the abolition of the slave trade. The reasons stemmed from the mission's initial strategy of creating a Christian colony, as well as the political and economic situation in the area.[101] The missionaries' assumption of judicial responsibilities

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99 McCracken 2000, pp. 68-69, 224-225. Until the establishment of the Mission Council in 1886, initially composed of ordained and medical missionaries, Laws was the undisputed head of the mission, and afterwards, as treasurer and secretary of the council, he often wielded autocratic powers in the mission in practice.

100 Ibid., pp. 70-84. The census of the Cape in 1880: 141 men, 202 women, 119 girls and 128 boys, in all 590 people. Livingstone 1921, p. 179.

101 McCracken 2000, pp. 65-88. The economy of the Yao chieftaincies depended on coastal trade, an important part of which was the slave trade, to which the Scots were fundamentally opposed. Apart from long-distance slave trade, domestic slavery had a central place in the economy of local societies, and could not be seriously challenged by the ALC or the missionaries. By the 1880s, the Yao had clearly rejected

over their dependants in Blantyre and Livingstonia ended in scandal after reports of floggings and a botched execution in Blantyre reached Britain in 1880. In 1881, when Livingstonia moved its base to Bandawe in uTonga, both missions were explicitly ordered to cease their temporal activities. At Bandawe, Laws made it a mission policy that only pupils and apprentices should stay with the missionaries, and that all other Africans wishing to settle near them needed to place themselves under the protection and jurisdiction of the Tonga chiefs in the area. During the 1880s, the mission expanded and new stations were founded in Northern Ngoniland, at the north end of the lake among the Ngonde and in Livlezi Valley in the south-west, among the Chewa and Chikuse's Ngoni.[102]

Period of expansion 1890-1914

Although Livingstonia expanded its sphere of operations and influence considerably during the 1880s, in terms of conversion its results remained very meagre until the 1890s. In uNgoni, the missionaries were not allowed to teach until 1886. In 1891, Livingstonia consisted of four European stations, with thirty-five schools in total,[103] and of these, only the stations in uTonga and uNgoni were to become centres of African conversion on a large scale during the next decade.

The 1890s witnessed a growth in the popularity of mission schools and a widespread adoption of evangelical Christianity among the Ngoni, the Tumbuka and the Tonga. As McCracken has shown, this process has to be seen in the context of the changing political, socio-economic and ecological conditions in the region. The mission was seen by the Ngoni, the Tumbuka and the Tonga to provide valuable new skills and opportunities through education in times of colonial conquest, economic change and rinderpest epidemic. A mission education was a considerable asset for migrant labourers or employees of the new colonial state.[104]

By the mid-1890s, the evangelistic techniques of the mission had also improved. The missionaries' understanding of the vernacular languages had developed, and African teacher-evangelists were increasingly taking part in the mission work. The younger generation of missionaries, notably Rev. Donald Fraser in uNgoni, introduced a new, dramatic and more emotional element to the evangelism, which appealed to Africans and yielded unprecedented

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mission Christianity and increasingly accepted Islam and coastal customs. By the time of the colonial conquest in the early 1890s, the ALC was in fact demanding that the government should use coercion in order to provide the necessary labour for the Company.

102 Ibid., pp. 98-103; 104-106; Oliver 1952, pp. 58-60; Porter 2004, pp. 269-270.

103 *Reports on Foreign Missions* for 1891-1893.

104 McCracken 2000, pp. 147-158. In Tongaland, the average attendance at mission schools rose from 1,600 to about 5,000 between 1895 and 1898, and the number of schools increased from 18 to 53. In Northern Ngoniland, where there had been only 630 pupils in 1893, there were over 4,000 in 1898.

results.[105] Following the first widespread conversions to Christianity, the Livingstonia Presbytery, first called "the North Livingstonia Presbytery of the Presbyterian Church of Central Africa" was founded in November 1899 as the governing body of the church, to which local Kirk Sessions sent representatives. By 1901, Livingstonia was clearly the most influential mission in Malawi, with considerably greater financial resources than its rival missions could muster. In terms of numbers of European staff, Livingstonia was the largest mission in the Protectorate until 1907, when it was overtaken by the UMCA and the DRC.[106] In the early 1900s the mission expanded in the Nyasaland Protectorate as well as in Northern Rhodesia, and its pupils and adherents included the Tumbuka, the Tonga, the Ngoni, the Ngonde, the Chewa, and the Namwanga (from Mwenzo) among others. Although the vast majority of the Overtoun Institution students came from the three northernmost districts of Nyasaland, there were also a number of foreign pupils, especially from Northern Rhodesia. New major stations had been established in Kasungu, Mwenzo, Chitambo, Chinsali and Tamanda, by the outbreak of the First World War.[107]

In 1894, the mission began its ambitious higher education programme, the brainchild of Laws, to establish an educational and industrial institution for African teachers, preachers, and artisans on the Khondowe plateau. In many ways, the Institution was a continuation of Livingstone's ideas developed and realised in Lovedale in South Africa by Stewart. This institution, later named the Overtoun Institution after its principal donor, Lord Overtoun, became the new centre of the mission. Laws obtained vast areas of land for the Institution from Rhodes's BSAC, displaying scant respect for African property rights, and secured vast water, timber, land and stone supplies. The Institution served both the mission and the emerging Presbyterian Church as well as the colonial economy. Apprentices were trained in skills such as building, carpentry, printing, engineering and telegraphy. After six years of normal school, the pupils were taught more advanced courses in teaching, theology, medicine and the arts. As a centre of Western post-primary education, the Institution was established years ahead of its later rivals in Nyasaland and Rhodesia. It provided an important uniting framework for Africans across the Livingstonia

105 Ibid., pp. 159-161; Thompson 1995; *Annual Report for 1901;* Hewat 1960, pp. 212-215; Pachai 1973, p. 89. By 1901, the mission had six main stations, five fully formed African congregations with 1,576 church members, 142 schools with 11,000 pupils and 531 African teachers, evangelists and preachers. European staff consisted of 29 missionaries and 13 missionary wives. In Livingstonia, "evangelist" came to mean a recognised, Institution-trained person with authority within the congregation beyond their preaching role. Before the ordination of the first African ministers in 1914, the "licenciated preacher" was the highest title available to the theologically-trained African churchmen.

106 McCracken 2000, pp. 217-218; Thompson 1995. The Kirk Sessions consisted of the reverends and the church elders. Initially there was one African elder from each major congregation in the Presbytery, but from 1907, the congregations were entitled to send one elder for every 300 members in full communion. Between 1875 and 1927, 147 missionaries were appointed to Livingstonia (including five South African evangelists). In addition, at least thirty-seven missionary wives (excluding inter-staff marriages) lived in the Mission for some period of time. McIntosh 1993, pp. 246-250.

107 *Annual Report for 1914;* Fetter 1989, p. 403; McCracken 2000, p. 188.

sphere of operations, and brought them together for periods of study of up to seven years. The academic curriculum for the higher classes at the Institution was exceptionally wide-ranging for the time, particularly under the leadership of James Henderson (headmaster of the Institution between 1898 and 1906).[108]

From 1894 to the 1910s, the Institution was a massive building project in the Khondowe area, and employed more than 3,500 workers in 1903. A road was constructed which ran from the high plateau to the lake, a piped water supply and electric power were installed, and permanent buildings, including Laws' "Stone House", the industrial departments, and the David Gordon Memorial Hospital (DGMH), were gradually erected. A village school network was established in the outlying areas. The Institution became an important economic centre in the north, and in the 1920s, it was the only significant market for maize and vegetables in the area and, apart from the Department of Public Works, the only European employer of labour.[109]

The Institution supported the colonial economy by producing skilled workers, but its policies of agricultural and industrial reform in Northern Malawi largely failed, as McCracken has shown. Livingstonia provided clerks, telegraphists, printers and other workers for the colonial administrations in the Protectorate and neighbouring territories, European planters and the mining industry in South Africa and the Rhodesias, but only a few graduates and apprentices become successful craftsmen, traders or modernising farmers in their home villages. By the 1930s, over fifty per cent of able-bodied men in the Northern Province were migrant labourers absent from their homes, and the conditions for local economic development were bleak. In its agricultural department, the Institution notably failed to compete with or improve upon traditional methods of cultivation. Furthermore, up to forty per cent of its apprentices and over half of its students left before graduating or were dismissed for various reasons. Although during its heyday, in the early years of the twentieth century, Livingstonia provided the highest academic education available in the region, the elite it trained was small. The Institution contributed significantly to the formation of new kinds of social differentiation among Africans on the basis of educational privilege.[110]

McCracken has pointed out the contradictions in Livingstonia's policies at the turn of the century. Despite the missionaries' aim of holistic religious, social and economic change in African societies, they rejected mass conversion, and the evangelical concept of instantaneous conversion through divine Grace. Admission to full church membership was a slow, supervised process from "Hearer" to catechumen to a baptised communicant. Education became a pre-

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108 Fetter 1989, p. 403; McCracken 2000, pp. 171-176. Between 1895 and 1926, the Institution Roll-Books recorded 1,238 students, although of these, only fourteen were female. After the establishment of the Institution, the name "Livingstonia" was used for both that station and for the mission as a whole.

109 McCracken 2000, pp. 171-185.

110 Ibid., pp. 171-195, 304. By 1915, although over 800 students had attended classes at the Institution, only some 350 pupils had graduated fully from the Institution central school. However, many of them remained in the Northern Province, and become important figures in the church and in local and regional politics.

condition of advancement to full membership: by 1906, admission to the catechumen's class had become conditional on the ability to read. As the mission introduced the policy of school fees from 1898, church membership became dependant upon a measure of wealth. Furthermore, the few missionaries with baptismal authority were only able to examine candidates slowly, resulting in delays and frustration among those awaiting baptism. After the turn of the century, Livingstonia was increasingly challenged by the independent African Christian movements of the Watchtower and the Seventh Day Baptists, who recruited their adherents largely from among those disillusioned with Livingstonia policies and colonial rule. However, during 1909 a large number of converts were baptised at Livingstonia, and the following year, Charles Inwood's evangelical campaign at the mission marked a new wave of religious revival and a regaining of the initiative by the mission in the region.[111]

The war and period of relative decline 1915-1930

In 1915, as McCracken has noted, despite the challenges from other missions and African independent Christian movements, Livingstonia was still "the predominant religious and educational body in the north". That year, the number of full church members (communicants), within the Livingstonia church was 10,203. The total Christian community at Livingstonia, including communicants, their families, catechumens and hearers, was estimated to be 38,000, in an area with an estimated total African population of 304,000. However, financially, the mission had been in difficulties for many years before the war. The annual expenditure of the mission had risen from around £8,500 at the turn of the century to £10,000 by 1906 and to over £12,000 in 1914. After the deaths of the old prominent Livingstonia supporters, it became impossible to raise sufficient funds from the diminishing group of businessmen who sat on the Sub-Committee. With the loss of adequate separate funding, Livingstonia lost its relative administrative independence. By the outbreak of the war, Livingstonia was under the auspices of the Foreign Missions Committee of the United Free Church of Scotland and was placed on the same administrative footing as the other missions of the church. During the war, the financial state of the mission became critical, as donations from Britain diminished. After the war, the church and the educational system at Livingstonia took a long time to

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111 Ibid., pp. 229-231, 244-264. In Livingstonia, the road to full church membership was particularly slow. Through confession of faith, people could become hearers, after a period of Bible study and prayer meetings they could proceed to catechumens, if they passed the oral examination and had a basic level of literacy. To obtain full membership, a further period of probation under surveillance, followed by a more thorough examination was necessary. The process often lasted for many years. See Sinclair 2002, p. 35, and Fields 1985. "Christian community" broadly understood, included "Hearers", "Catechumens", church members (baptised and entitled to full communion) and their families.

recover. Financial strain forced the mission to withdraw from its stations at Kasungu and Tamanda in the early 1920s.[112]

The war seriously disrupted the day-to-day operation of the mission. The northernmost stations of Mwenzo and Karonga were caught in the war zone of the East African campaign. Mwenzo was abandoned by European missionaries and ransacked by German forces, while Karonga station was turned into a British military hospital. Both missionaries and African teachers and evangelists were called up to military service. Africans served as military porters, guides, interpreters and recruiting sergeants. The demand for porters continued until the end of 1918. By 1918, over half of the Scottish missionaries from Livingstonia were engaged in war service, and large stations were often staffed by a single European. In 1919 and 1920, the total European staff at Livingstonia was less than it had been at Cape Maclear.[113]

The British occupation of south-west German East Africa placed the mission under further strain. The German missionaries working there were deported, and their leaders approached Laws, asking whether the Scots could temporarily oversee their stations in their absence. Laws agreed, and together with the UMCA and Blantyre missions, Livingstonia was allowed to send its African agents to operate in the Langenburg district in 1917. Three years later, European missionaries were allowed to follow, and Livingstonia operated in the Tanganyika Territory until the return of the Germans in 1925–27.[114] In 1927 the Livingstonia sphere of operations was about 57,000 square miles, twice the size of Scotland. At this time, the population of the region was estimated to be 400,000: about seven people to the square mile.[115]

The demands made by the military during the war, particularly the *tengatenga* (carrier) service forced upon Africans, caused considerable suffering and provoked widespread resentment among the African population. The carriers suffered from disease, hunger and maltreatment, and were sometimes flogged and forced to carry excessively heavy loads. Many Africans questioned their conscription into what they saw as the Europeans' war. The war itself cast considerable doubts over missionary claims that Christianity was a religion of peace and that Europeans were true Christians. Furthermore, the Livingstonia missionaries unquestioningly sent their teachers and employees into the war service, even after the terrible conditions of the carriers were commonly known. This alienated many Christians from the missionaries, although in Northern Malawi, there was no active support for the Chilembwe Rising of 1915, when John Chilembwe led a short-lived armed revolt against the British. Those

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112 McCracken 2000, pp. 264, 271-274; McIntosh 1993, pp. 172, 192. The estimates of the total African population, which were not based on any census, are almost certainly too low. Fetter has noted that even the best colonial population censuses undercounted adult men and systematically inflated the age of teenage girls. Fetter 1989, p. 400.

113 Livingstone 1921, p. 358; McCracken 2000, pp. 266-267. In the Institution, teaching continued until early 1916, when the teachers were released for government service.

114 McCracken 2000, pp. 267-275; Wright 1971, pp. 145-146.

115 *Report on Foreign Missions for 1927*, p. 15.

Africans who protested openly, including the Ngoni paramount Chimtunga, were deported or imprisoned during the war.[116]

However, the First World War also provided African teachers, evangelists and the first ordained ministers at Livingstonia with increasing opportunities to become independent leaders in Christian communities beyond missionary supervision. The first three ordained pastors, Jonathan Chirwa, Hezekiah Tweya and Yesaya Zerenje Mwasi, all took practical control of their congregations during this period. Evangelists also took on increasing responsibilities within the Christian communities. Between 1914 and 1927, thirteen African ministers were ordained in Livingstonia. In 1918, Y.Z. Mwasi was elected as the first African Moderator of the Livingstonia Presbytery. Although the missionaries continued to wield considerable powers through their exclusive Mission Council, during the 1920s African Christians gained a clear majority in the Presbytery and in the local Kirk Sessions. With the retirement of almost all of the influential pioneer missionaries by 1930, the balance of power in the church shifted steadily towards the African leadership. In 1930, the historic mission stations of Bandawe, Ekwendeni, Loudon, Karonga and the Institution still remained important missionary centres, but the church extended far beyond them. There were thirty-one congregations, with the number of full members fluctuating between less than three hundred in the smallest, and over eleven hundred in the largest congregations. Twenty ministers, thirteen of whom were African, supervised the congregations. The ministers were assisted by about thirty experienced evangelists and a number of locally elected elders. The unpaid elders played a vital role in the church, organising church services, preaching, instructing candidates for baptism, visiting the sick, settling quarrels within the Christian community and reporting cases of misconduct to the Kirk Sessions, which functioned as local disciplinary courts.[117] In 1924, the Livingstonia and Blantyre Presbyteries united and formed a Synod of the Church of Central Africa Presbyterian. Two years later, the Nkhoma Presbytery of the DRC was admitted to the union. Each of the three Presbyteries retained their own constitutions, special characteristics and largely independent decision-making.[118]

The financial crisis and the war took a heavy toll on the mission school network with the loss of African teachers, missionaries and money. The younger missionaries increasingly questioned the value of Laws' educational programme and the post-primary education offered at the Institution, while other missions challenged Livingstonia's educational dominance. The mission's proportion of total schools in the Protectorate fell from over thirty per cent before the war to sixteen per cent in the early 1920s. In terms of the numbers of

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116 McCracken 2000, pp. 269-270. On the Chilembwe Rising, see Shepperson and Price 1958.

117 McCracken 2000, pp. 270-271, 290-296; McIntosh 1993, p. 245; Ncozana 2002, pp. 153-154; Thompson 1995, 153-161, 175-176, 226.

118 McCracken 2000, p. 293. European ministers were recognised as full members of the Presbytery, but were not subject to its jurisdiction. The Synod met only three times between 1924 and 1933.

both schools and converts Livingstonia was overtaken by the White Fathers and the DRC, and by the early 1920s, Livingstonia had become merely one mission among the many established in the Protectorate. Laws' visions of higher education and European-style industrial training were challenged by the younger missionaries led by Donald Fraser. In 1925, the mission authorities elected W.P. Young as Laws' successor, and Laws was formally called upon to resign at the end of his term. In September 1927, illness finally forced Laws to leave Livingstonia, and his educational schemes were buried. Under Young's leadership, the Institution became a training centre for primary school teachers rather than a regional centre of secondary education. It was later widely acknowledged that the educational standards at Livingstonia dropped significantly during the 1920s and the 1930s.[119]

During the inter-war period in Northern Malawi, a number of new, independent African churches emerged. Some of them, like the older Watchtower movement, appealed strongly to those who were disappointed with the denial of perceived mission privileges, or to those who rejected the Eurocentric moral code of Livingstonia. Other churches, however, were the result of secession from Livingstonia and differed less markedly from the Mission. Between 1928 and 1934, four major secession churches, three of them founded by prominent African churchmen were established. Yaphet Mkandawire, a minister removed from office for *phemba* medicine drinking, formed the African Reformed Presbyterian Church in 1932. In 1933, Y.Z. Mwasi, the first African Moderator in Livingstonia, left the mission and formed The Black Man's Church of God. In 1934, Charles Chinula, a minister who had been suspended four years earlier, founded the Eklesia Lanangwa (Church of Freedom). In 1935, these three ministers joined forces to form the *Mpingo wa Afipa wa Africa* (The Black Man's Church in Africa), a body with thirty-five elders and over two thousand members.[120]

Beyond the Presbyterian and independent churches, the mission-educated elite took on a prominent political role, forming several Native Associations during the 1920s. The North Nyasa Native Association was founded, with missionary encouragement, in 1912 in Karonga by Livingstonia graduates, and similar associations were planned in several districts. The war disrupted this development, but in 1920, the Mombera Native Association and the West Nyasa Native Association were firmly established, followed by associations in the Central and Southern Provinces of the Protectorate. These associations brought together the local educated elite and the more traditional leadership, including

119 McCracken 2000, pp. 265-288, 312-313. Fraser and his allies argued that the mission should concentrate upon providing mass education in the village schools, emphasising those skills deemed important for "traditional" African village life rather than providing higher education and training in European skills for the few. In this they echoed the emerging new colonial educational policies exemplified in the views of T.J. Jones and the Phelps-Stokes Commission. Laws, in contrast, wanted to rebuild and expand the Institution to realise his dream of "the Overtoun College of the University of Livingstonia". The abandonment of Laws' ambitious scheme in 1926 marked his defeat and his declining position as the leader of the mission.

120 Ibid., pp. 321-324.

churchmen, teachers and members of the colonial service (businessmen as well as chiefs and headmen). Education was a practical precondition of membership. The associations generally supported the colonial order, but tried to inform the government about African concerns during the post-war period of economic crisis. They demanded economic and social improvement, and protested against the ill treatment of Africans by European colonialists. Among their key demands were support for African enterprise and education. The lowered standards of mission education offered by Livingstonia were also increasingly criticised, with demands that the government should take over the Institution and develop it further. The associations lacked any means of effective protest, however, and avoided direct confrontation with the authorities. Although some of their complaints led to minor improvements, their major demands were generally rejected by the government. However, as McCracken has argued, the importance of "the associationists" should not be overlooked. Many of them were also prominent in the churches and native authority courts, which were other vehicles of "politics of privilege" for the mission-educated elite in Northern Malawi.[121] Both the independent churches and the native associations had important connections to Livingstonia, and in this study both are discussed in order to chart the African quests for health in the region in the early twentieth century.

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[121] Ibid., pp. 304-321.

3 MISSIONARIES AND MEDICINE IN THE VICTORIAN SCOTTISH MISSIONARY SCENE

3.1 The missionary background: themes and approaches

David Cannadine has pointed out that although the British Empire has been extensively studied both as a racial and a gender hierarchy, it has received far less attention as a social hierarchy, organism or construct. Cannadine has convincingly argued that when studying British perceptions of, and attitudes towards, their empire, it is imperative to consider the British view of their own society and domestic social order.[1] This approach is indispensable not only to the study of the imperial administrators and theorists, but also to the study of British missionaries who preceded or followed the flag to all corners of the globe during the imperial expansion. It is important to consider the social background of the Scottish missionaries of the late Victorian era and to understand their views of Scottish and British society, which would form the basis of their perceptions and attitudes towards Central African societies.

A study of the Victorian Scottish Presbyterian foreign missionary movement must examine the origins and contexts of the movement in eighteenth-century and early nineteenth-century Britain, on both sides of the Scottish border and across the Atlantic. Although there were many unique aspects and trends in Scottish religious life, the religious scene in both England and the United States influenced important exchanges and developments in Scotland, not least in the missionary enterprise.

From the 1750s to the 1830s, the Established Church of Scotland was dominated by the Moderate party, which was influenced by both Enlightenment thinking and English aristocratic culture. The moderates weakened the old Presbyterian doctrine, rhetoric and style, favouring in their place refinement, moderation in religious attitudes and, in Callum Brown's

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1 Cannadine 2001, pp. 3-10 and *passim*.

words, "philosophizing rather than remonstration in pulpit discourse".[2] The Moderates allied themselves with the rural landed classes and the government, and established themselves as the dominant, although not necessarily the largest, group amongst the Scottish Presbyterians.

Towards the end of the eighteenth century, the moderates were increasingly opposed by the evangelicals, both within the established Church (in which they formed the Evangelical party) and in the dissenting churches, such as the Relief Church founded in 1761. Evangelicalism was less a theological system than a framework of response to urbanisation and industrialisation. However, although it was a crucial feature of the identity of the new middle classes, and arguably governed by them, evangelicalism was not a solely middle-class phenomenon. Voluntary evangelical activities cut across the class boundaries, and the recipients of home mission work included members of both the middle and the working classes. By the 1790s, the evangelicals in Scotland had formed strong links with the English evangelicals, with whom they shared religious temperament, attitudes and interests. The English and Scottish evangelicals and Methodists reacted against the social elites with their "lukewarm" attitude towards religion and gathered their support from the groups most affected by the ongoing economic changes in agriculture, commerce, and industry: the lower classes and the new entrepreneurial middle class. Preachers were exchanged across the English–Scottish border, and joint campaigns, including the anti-slavery movement headed by William Wilberforce, were initiated, and co-operation in evangelisation work began in Britain and abroad through home and foreign missions.[3]

Many of these new initiatives were undertaken not by the Protestant churches themselves, but by voluntary societies who relied upon their own fundraising. The first new foreign missionary society was founded by the English Baptists (1792), followed by the London Missionary Society (1795) and the Anglican Evangelical Church Missionary Society (1799). The missionary movement was not, of course, limited to Britain. By the end of the nineteenth century, almost every nominally Christian country and denomination was involved in foreign missionary work.[4]

The Protestant missionary movement was originally an almost exclusively evangelical phenomenon. In England, the High Church was involved primarily through the Society for the Proclamation of Gospel (SPG) and later, with the establishment of the Universities' Mission to Central Africa (UMCA) in 1859. These societies remained minorities within the British missionary field, however. In Brian Stanley's words, "the thought-forms of nineteenth-century evangelicalism remain the key to evaluating the most characteristic features of the ideology of the missionary movement".[5] At the heart of evangelical thought and action was the often exclusive emphasis on the message of the atoning

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2 Brown 1987, p. 16.
3 Ibid., p.16, 34-37, 136; Checkland 1980, p. 65.
4 Neill 1986, p. 214.
5 Stanley 1990, p. 61.

death of Christ on the Cross. Many early missionaries left Britain firm in the belief that the message of the Cross, was the only thing the "heathen" needed to hear in order to "regenerate" their lives and societies. In evangelical theology, "regeneration" was associated with everyday Christian life – with the expected spiritual growth and second birth through faith – as opposed to those Christian traditions that associated "regeneration" with baptism. In a reaction against Enlightenment rationalism, the evangelicals were hostile to any merely moralistic, rational or abstract form of religion. Although, as Stanley has argued, the evangelicals emphasised enthusiasm, experience and activism, they also borrowed extensively from Enlightenment thinking. Reason was highly valued, and was seen as complementing biblical faith. Natural theology supported the claims of biblical revelation. For early nineteenth-century evangelicals, the universe was seen as a harmonious system that followed the natural laws of God. These laws were moral as well as physical: shaping civilizations and cultures as well as the natural world. The concept of divine providence, which had been central to the earlier Calvinist theological tradition, became the pre-eminent concept which greatly influenced the ways in which evangelicals responded to events in their lives and to the unfolding of history.[6]

As the Victorian era progressed, this evangelical consensus began to lose its form and pervasiveness. The confidence in reason and order was somewhat weakened by the influence of European Romanticism.[7] The distinctive evangelical blend of biblical assumptions and Enlightenment ideas remained potent in many aspects of the missionary field, however. It can be argued that this was especially the case in some forms of Scottish Presbyterian missionary thought, in which the concept of divine providence as well as an emphasis upon education and the dissemination of Western rational knowledge continued to be of importance.

During the first half of the nineteenth century, the prevailing attitude among the evangelicals in Scotland assumed that a harmonious relationship existed between science and religion. Although there were tensions between evangelicalism and science, Thomas Chalmers (the leader of the Free Church and first principal of New College, Edinburgh) had no difficulty in gathering a distinguished circle of scientists and theologians around him, combining evangelical theology with scientific practice. Elaborate schemes of harmonisation were devised to reconcile the progress of geology with the integrity of the Bible, for example. As David Bebbington observes, in this context science and religion were understood to be part of the same divine order.[8]

In Scotland, the evangelical movement expanded within the wider context of a growing industrial economy and urbanisation, a social environment in which entrepreneurial skills and individual initiative were becoming crucial to success. However, there was also a popular Gaelic countryside element in

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6 Ibid., pp. 62-63; I am grateful for Professor Andrew Walls for additional information on evangelical theology.
7 Ibid., pp. 61-63.
8 Bebbington 1999, pp. 22-23.

Scottish evangelicalism, with a major revival in the Highlands in 1859. Evangelicalism became largely associated with the holistic advance of the individual, in religious as well as economic and social spheres of life. There were also significant transatlantic connections within the movement. In 1874, American evangelists Dwight Moody and Ira Sankey attracted thousands to their meetings in Glasgow and Edinburgh. Among those who attended the meetings were Henry Drummond, the future reconciler of evangelicalism and evolutionism, and Robert Laws, a young medical student preparing for the foreign mission field.[9]

The pre-eminent Scottish missionary theorist of the nineteenth-century, Alexander Duff, developed his schemes of evangelisation and education in Calcutta, where from 1830 he was the headmaster of a central Church school. Duff emphasised the role of education believing that its long-term effect would transform the whole of Hindu society from within. Following the vision of his mentor Chalmers, Duff taught biblical studies within the broader context of the entire Enlightenment arsenal of knowledge: philosophy, natural science, mathematics, astronomy, and so forth. Other Scottish mission educationalists in India developed similar methods, and although this approach was severely criticised for its drain on resources, concentration on the higher castes and for overlooking the poor, the educational tradition remained strong. Throughout the nineteenth century, the Scottish missions held fast to the conviction that a total Christian world-view should include both Christian faith and Western-style education. The prime examples of this were to be the Scottish missions in Malawi, which formed communities in which education, agriculture, technology and medicine were all seen to derive from and be connected to the proclamation of the gospel.[10]

The Scottish overseas missionary movement had its roots in the earlier eighteenth-century home mission work in the Scottish Highlands and Islands, a home mission field of a type that did not exist in England. The Scottish Society for Propagating Christian Knowledge (SSPCK) was founded as early as 1709. In addition to the mission enterprise in the Highlands and Islands, the society also contributed to the mission work among the Native Americans in North America. By the end of the eighteenth century, the evangelical awakenings at home and missionary enterprise abroad had become closely intertwined in Scottish missionary thought and action. Not only evangelicals, but also many moderates in the Scottish Church could subscribe to the programme for the propagation of Christianity through education, based on the experiences of the Scottish Reformation and the mission to the Highlands. The perceived evils which undermined the SSPCK in the sparsely-populated Gaelic-speaking Highlands and Islands during the eighteenth century, for example, "error, idolatry, superstition, and ignorance"[11], would be largely the same in the foreign missionary fields of the following century.

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9 Brown 1987, pp. 138-139; Brown 1997, pp. 84-92 and *passim*. Bebbington 1999, pp. 28-29; Livingstone 1921; McIntosh 1993; Interview with Andrew Walls, December 2002.

10 Walls 1993, p. 571-572.

11 Quoted in Checkland 1980, p. 73; Brown 1997, pp. 84-94; Walls 1993, pp. 567-568.

The Scots played an important part in the founding of the first English foreign missionary societies, especially the LMS. According to Andrew Walls, for at least half a century the LMS was a major, perhaps the predominant, influence upon Scottish missionary thought. The LMS provided a model for the first Scottish foreign missionary societies, the Glasgow Missionary Society (GMS), and the Edinburgh Missionary Society (EMS) founded in 1796. The new societies gradually replaced the old SSPCK, which had enjoyed the support of both moderates and evangelicals. At least sixty-one local mission societies were founded between 1796 and 1825, some of them as auxiliaries to larger societies, although many of them were independent, and gathered and disseminated information about missions and contributing to missionary causes both at home and abroad. In the early nineteenth century, Scottish women also organised a number of associations and societies to promote the missionary cause. The various societies recruited a number of speakers, local office-bearers, collectors and writers for the Missionary Magazine founded in 1796. Each of the Scottish Universities (Aberdeen, Glasgow, St. Andrews and Edinburgh) had a student missionary society by 1825. Edinburgh and St. Andrews Universities, in particular, educated the most influential of the new missionaries, including Alexander Duff.[12]

Although interest and enthusiasm for overseas mission activity was widespread at the turn of the century, the initial results were meagre and early mission schemes often ended disastrously. There was strong opposition to the missionary enthusiasts within the established Church. Many moderates opposed the new societies for political reasons, as these societies, which were beyond Kirk control, contained suspicious dissenters. Some were unimpressed by the overtly emotional calls to convert the heathen; others, drawing upon the strict Calvinist tradition, argued that if the Lord had wanted missions, He would have organised them Himself. The Church of Scotland in 1796 declined to appoint a foreign missionary committee to supervise overseas mission work. Only the GMS and the EMS sent out missionaries on a regular basis – initially to the West African colony of Sierra Leone. Other early Scottish overseas mission areas included Jamaica, India and Southern Africa. Despite some initial disasters, and few actual converts, by the 1820s foreign mission work had become an acceptable activity for the established Church. The churches gradually took over the overseas mission work from voluntary societies during the 1830s and the 1840s.[13]

By the mid-nineteenth century, there were three Scottish Presbyterian Churches undertaking foreign mission work: The established Church, the United Presbyterian Church, and the Free Church of Scotland. In 1900, the latter two churches united to form the United Free Church. The United Presbyterian Church (hereafter the UP Church) was founded in 1847, as a union between the Secession Churches (going back to 1733) and the Relief Church. The new UP

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12 Hewat 1960, pp. 8-9; MacDonald 2000, pp. 111-115; Walls 1993, pp. 568-569.

13 Checkland 1980, p. 66; Hewat 1960, pp. 11-15, 34-35; Walls 1993, pp. 569-570. Interview with Andrew Walls, December 2002.

Church was, in Brown's words, "a powerful, strongly middle-class and...predominantly urban denomination", which exerted a strong influence in Glasgow and Edinburgh. Its traditionally strong Calvinist doctrines had been liberalised by the final quarter of the century, when the distinctive traits that distinguished it from the Free Church rapidly eroded, making their union in 1900 possible. The Free Church, which broke away from the established Church in the Disruption of 1843, under the leadership of Thomas Chalmers, also had a strong urban and middle-class character. Many of its members were upwardly mobile businessmen, agents and bank staff. Consequently, its urban wing largely had the ethos, style and outlook of the bourgeoisie. The Free Church emphasised temperance and Sabbatarianism, and confined its social intervention largely to the private spheres of life, allowing industrial society to develop according to economic forces.[14] However, Victorian Scottish evangelicalism should not be characterised as being entirely urban or middle-class, because the movement was also strongly influenced by rural Gaelic values.[15]

During the Disruption, the established Church lost a third of its ministers to the Free Church, as well as most of its evangelical backbone: the Sunday School teachers, temperance activists, and all but one of its foreign missionaries. By the last quarter of the nineteenth century, the established Church could claim only fifteen per cent of the total population of Scotland as its adherents. The moderates in the church gradually lost their position to the evangelicals, and membership of the established Church began to grow. Finally, in 1929, the vast majority of dissenting churches rejoined the new "National Church of Scotland".[16]

The Disruption caused considerable difficulties in the foreign mission field. In many places, the Free Church missionaries had to relocate whilst the established Church, which owned mission property, was struggling to recruit new staff. Strained resources marked most of the overseas mission work for the remainder of the nineteenth century. Even the death of Livingstone in 1873, which has often been referred to as marking a new wave of interest in foreign missions, did not increase overall mission funds significantly.[17]

By the early Victorian period the self-adopted term "evangelical" had united the vast majority of Presbyterians in Scotland, and nonconformists and Methodists in England. Local and national government largely supported evangelical campaigns to reform urban, industrial society by promoting godliness and churchgoing, and attacking "immorality" (especially drinking and prostitution). In Scotland, the leading evangelical campaigner of the early

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14 Brown 1987, pp. 38-40; Cheyne 1983, pp. 112-113; Drummond and Bulloch 1975, p. 20; Bean and van Heyningen 1983, pp. 5-6.

15 Interview with Professor Andrew Walls, December 2002. Gaelic-speaking Livingstonia missionaries included Nurse Margaret McCallum. McCallum to Rev. Finlay Graham, Kinlochwe 23 October 1898. NLS, Acc. 7548 D 69, Letters to the Livingstonia Sub-Committee 1898–1900, 80.

16 Brown 1987, pp. 28-33; Walls 1993, p. 572.

17 Walls 1993, p. 572. Per person, the UP Church members contributed most, followed by the Free Church.

period had been Chalmers, who opposed state-supported charity, stressing Christian responsibility, self-help and self-determination instead. In order to address the serious urban problems within Scotland, the Scottish evangelicals established many new voluntary agencies (especially in Glasgow), some of which were new inventions while others, including the temperance movement, were modelled after the American example.[18]

Personal virtue, temperance and education were for many early Victorian Scottish churchmen the best means of improving society. However, in the 1840s and 1850s, the importance of social reform through the improvement of the material conditions of the poor was increasingly stressed by reverends like James Begg. For Begg, the moral and physical causes of social "evils" such as pauperism and crime were interconnected: *"Moral degradation leads to physical, and physical again plunges its unhappy victims into deeper moral debasement, and both causes working together soon destroy the very foundations of the social fabric."* Norman Macleod, one of the most popular ministers of his day, believed that the church should not overlook the bodies of men in its concern for their souls, and argued that both the spiritual and temporal interests of mankind deserved attention. Christian social commentators, including Begg and Macleod, who combined the moral and the physical were in line with the emerging medical missionary movement in nineteenth-century Scotland. In late Victorian Scotland, the churches were increasingly attempting to address the perceived social problems of the country: sexual immorality, unhealthy housing and the drinking of spirits.[19]

Strong drink was a predominant urban concern in Victorian Scotland, in both medical and religious circles. During the first half of the nineteenth century, the consumption of spirits, especially whisky, introduced from the Highlands, increased approximately fourfold between 1815 and 1840. It was estimated that in 1841 one in ten houses in Glasgow sold alcohol. In 1929 the Scottish Temperance Movement was founded in order to combat excessive drinking, which was associated with crime, poverty and disease. During the Victorian period, the Free Church, in particular, was closely linked to the temperance movement. Most of the pioneering Scottish medical missionaries who went out to Central Africa had experience of mission work in the urban slums of Glasgow and Edinburgh. Four of the early Livingstonia doctors came from the Wynd Mission congregations in Glasgow.[20] The importance of Laws' experiences of mission work in Glasgow, where he witnessed scenes "almost unbelievable in their degradation and wickedness", was described by W.P. Livingstone (biographer of Laws and editor of the United Free Church *Record*):

> These experiences proved a valuable part of his training: they helped to lessen the inevitable shock when he came in contact with primitive races, and fitted him in a peculiar way to meet and combat the debasement of heathenism.[21]

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18 Brown 1987, p. 17.

19 Cheyne 1983, pp. 119-120, 131-135, 159-160; Begg, quoted in Cheyne 1983, p. 126.

20 *The Record of the United Free Church of Scotland,* July 1927, pp. 327-329; Drummond and Bulloch 1974, pp. 28-29; Hamilton 1981, pp. 182, 218-220; McCracken 2000, p. 221.

21 Livingstone 1921, pp. 28, 34.

This passage is an excellent example of how home and foreign "heathenism" and "degeneration" were connected, and how the figure of the medical missionary as urban and African regenerator was created in missionary discourse. As many scholars have shown, nineteenth-century British missionary perceptions of Africans and the poor at home, and the languages of class and race influenced and interacted with each other. Colonial contacts were shaped by experiences at the metropole, and perceptions at the metropole were adjusted and influenced by colonial visions. A positive reading of this would be that the analogy between the colonial "others" and the white poor lessened racist classification. However, it could equally be argued that this analogy resulted in the classification of the urban poor as a race apart, and reinforced the need to colonize and control both Africans and the British poor.[22]

Voluntary organisations in Scotland had become increasingly religious in character during the late eighteenth and early nineteenth centuries, and provided spheres of respectable and purposeful leisure activity for the middle classes. From an evangelical perspective, most of the country's urban social problems were the result of the moral and spiritual failure of the individual. Consequently, evangelicals aimed to isolate the specific causes of failure and develop separate agencies to tackle these causes. Sunday and mission schools would increase literacy and give "the poor" access to the Bible; tract distributors would provide moral guidance to the literate; penny savings banks would encourage economic progress; temperance and teetotal societies would save the working classes from the perils of drink; sanitary societies would advise them on hygiene; model lodging houses would improve morality as well as sanitation; and co-operative building societies would encourage self-improvement. Glasgow became the centre for most of these voluntary societies. During the second half of the nineteenth century, evangelicals established schools for destitute children, embraced religious revivalism and founded youth movements such as the YMCA, YWCA, Boy's Brigade and the Girls' Guild. In Aberdeen, Robert Laws was a member of the Young Men's Mutual Improvement Association where, at the age of twelve, he read a paper on David Livingstone.[23]

The heyday of this voluntary evangelicalism lasted from the 1850s to the 1880s. The voluntary organisations were funded by rich evangelical entrepreneurs, and their rank and file workers, such as Sunday school teachers, were recruited from the lower middle classes. The early city missionaries were often men who felt they had a vocation but could not afford to complete their theological studies. By the 1850s, home missions also recruited both men and women from the working classes. The founding of the Scottish missions in Central Africa coincided with this fervour for Scottish home evangelicalism, and although the period from 1880 to 1914 witnessed a gradual decline of interest among all classes in the voluntary evangelisation project, the

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22 Comaroff and Comaroff 1997, p. 317 and *passim*; Thorne 1997, pp. 238-254 ;Youngs 1994, p. 70.

23 Brown 1987, pp. 17, 141-143; Checkland 1980, pp. 66-73; Cheyne 1983, pp. 120-127; McIntosh 1993, p. 5.

enthusiasm in the foreign mission field, and especially for the missions in Africa, lasted well into the twentieth century. In general, foreign mission enterprises were better funded than the home mission in the nineteenth century.[24]

Although the career of Livingstone, culminating in his martyr-like death in 1873, did not prompt a significant increase in contributions to foreign mission schemes in Scotland, his death certainly marked a moment when missionary work in East and Central Africa, especially the struggle against the slave trade, became more interesting to the Scottish public than ever before.[25] During the last quarter of the century Africa became, for many, the most fascinating mission field as one Free Church writer pointed out in 1893:

> I must say candidly that neither Africa nor its people were very interesting to us in those days [the 1840s]. India was the land of poetry and romance...In comparison with India, Africa and its people were dull and uninteresting. I mention this in order to contrast with it the overwhelming interest which Africa creates now. All eyes are turned to the Dark Continent.[26]

An outstanding example of the "vice-presidential class" of Victorian Scottish evangelicalism was John Campbell White, Lord Overtoun (1834–1908): the man who largely funded the Livingstonia Mission. During the 1860s, he inherited a booming chrome manufacturing concern. As he expanded his business, he also became a major benefactor of the Free Church and various voluntary organisations including the Glasgow Medical Missionary Society (GMMS) which funded the building of churches and paid the salaries of ministers and missionaries. He was the president of the GMMS, and among his many commitments, Overtoun paid the salaries of three Livingstonia medical missionaries (£250–£300 each)[27] until his death.

3.2 The medical missionary in the Scottish missionary movement

> In like manner must the Doctors…consider themselves as missionaries; and that all they do must bear upon conversion and edification of souls. The health of the people, the sanitary arrangements of the Mission, the instruction of the natives in the proper observance of the laws of health, and in the expediency of improving their dwellings and modes of life, must all be regarded as religious work. In advocating temperance, in discouraging obnoxious and debasing practices, they will most materially help on the good cause, and prove themselves what they are sent out to be – the associates of the Minister, and servants of the Lord.[28]

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24 Brown 1987, p. 175; Checkland 1980, pp. 77-78; Thorne 1997, pp. 246.

25 Drummond and Bulloch 1975, pp. 139-149, 167; Hewat 1960, pp. 1-10; Oliver 1965, p. 35; Walls 1993, p. 572.

26 *Jubilee Number of Free Church Monthly Record 1893*, Letter XV, p. 18.

27 Brown 1987, p. 175; Livingstonia Mission Staff-Book, NLS, Acc. 7548 D 73.

28 General instructions to the missionaries, Church of Scotland East African Mission [Blantyre], 13 July 1881, p. 4. NLS, MS. 7606, 1.

In many ways the evangelical-led movements for urban social reform in early nineteenth-century Britain were concerned with issues of sickness and health, and consequently strong links were forged between the evangelical reformers and the medical profession. However, in the foreign mission field, it was not until the latter half of the nineteenth century, that major developments in the deployment of professional medical missionaries took place.

C. Peter Williams has noted that early nineteenth-century attitudes towards the practice of medicine in mission work had tended to be largely suspicious. Williams has explained this scepticism as, in part, arising from the attitudes of the clergy, who controlled the most influential missionary societies, and partly because the medical profession had yet to undergo a professional and scientific revolution. The early Victorian clergy was not impressed by the medical profession – and in particular, the surgeons who formed the bulk of those medical men aspiring to join the mission field – whose social status was still clearly inferior. By the final three decades of the nineteenth century, however, the situation was changing rapidly. After the Medical Act of 1858 and the creation of a medical register of practitioners, the medical profession gradually became effectively policed. This contributed to the increasing respectability and status of the medical graduates who applied to work in the mission field. The process was further boosted by a considerable increase in the efficacy of Western medicine during the late Victorian and Edwardian periods. As the prestige and numbers of medical professionals rose, the proportion of clergymen in the middle-class declined steadily. At the same time, the proponents of medical missions were becoming more vocal. Walls has classified their main arguments under four headings: firstly there were imitative reasons, based on imitating the healing work of Christ; secondly, there were humanitarian or philanthropic reasons for helping the suffering; thirdly, there were utilitarian reasons, for the provision of medical aid to missionaries themselves; and finally there were strategic reasons, the use of medical missions where no other form of missions were successful or allowed to operate. In late nineteenth-century Africa, utilitarian reasons were particularly prominent.[29] Furthermore, the advocates of medical missions placed significant emphasis on the potential of Western medicine to attack the medico-religious beliefs and practices of other cultures.[30]

The Edinburgh Medical Missionary Society (EMMS), the pre-eminent Scottish society for the promotion of medical mission work, was founded in

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29 Hastings 1994, p. 276; Williams 1982, pp. 271-274; Walls 1982, pp. 287-288. Dr Macgovan, an American medical missionary in China and Japan, argued, in 1860, that medical missions were useful for the care of the missionaries and their families, to conciliate Chinese and Japanese people, and *"to counteract the evil influences exercised by our Godless fellow-countrymen in those lands." Conference on Missions held in 1860 at Liverpool.* London 1860, pp. 275-276. McGovan held that were it not for the medical missions, there would be "an extermination or general massacre" in China instead of merely riots against Westerners. However, he also praised the medical men of the British army and navy, particularly for the medical help rendered by them to the missionaries and referred to them as "assistant medical missionaries".

30 See, for example, *Lectures on Medical Missions 1859,* pp. 48, 56; Lowe 1886, pp. 39-41.

1841. The founding of the EMMS was inspired by a lecture given by a visiting American missionary doctor, Peter Parker, possibly the first modern missionary doctor who had worked in China since 1834. Parker, together with a colleague from the East India Company, had founded the Medical Missionary Society in China in 1838. Attending Parker's lecture in Edinburgh were a number of leading evangelicals including several professors of medicine, one of whom, Dr John Abercombie, became the first president of the EMMS. The aims of the EMMS were twofold: firstly, to train doctors as medical missionaries, and secondly, to persuade the churches and the mission societies that medical missionaries were indispensable to mission work in the field. The society wanted trainees of the highest possible academic calibre and decided that training for missionary work should be undertaken whilst the trainees were studying medicine in Edinburgh. For this purpose, the EMMS founded the Cowgate Medical Mission Dispensary and Training Institute, located in one of Edinburgh's worst slums. The students would live and work in the Institute, helping the resident doctors and attending prayer meetings and Bible study groups, thus gaining both medical and missionary experience. Another feature of EMMS policy was that once in the foreign mission field, its trainees should begin teaching medical skills to indigenous peoples as soon as possible. The founder of the Cowgate institute was William Burns Thomson (1821–93), who was appointed superintendent of the Cowgate dispensary in 1858.[31]

A former medical missionary in India, long-serving EMMS secretary and superintendent of its Cowgate Institute, John Lowe (1835–92) was one of the most influential Scottish medical missionary protagonists of his time. He took up his appointment in Edinburgh in 1871, and held his position within the society until his death. In 1886, he published *Medical Missions: Their Place and Power,* a frequently reprinted work on the importance and relevance of medical missions. For Lowe, the Bible provided the first line of defence for medical mission work; Jesus was the "Great Physician", Luke had been "the beloved physician", and the Acts of the Apostles could be interpreted as "the first report of the first Medical Missionary Society".[32] Lowe, like the earlier medical mission protagonists, emphasised that medical mission work was genuine evangelisation, not mere philanthropy, and that it should be recognised as the right hand of the church. Furthermore, he argued that it was essential that a medical missionary should be a qualified professional and that medical missions should operate in all missionary zones, not merely in the pioneering areas. The writings of the medical mission activists influenced a growing generation of future missionary doctors and nurses, including Robert Laws who, after reading of the "superior influence exercised by medical missionaries", decided to take a medical course as part of his ambitious University curriculum.[33]

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31 Checkland 1980, pp. 80-81; Ross 1988, pp. 91-92; Williams 1982, p. 281.

32 Lowe 1886, pp. 12-17; *Dictionary of Scottish Church History & Theology*, pp. 498.

33 Lowe 1886, pp. 28-30, see also *Lectures on Medical Missions*, pp. 47-48; Therapeutes 1859, pp. 125-131; Livingstone 1921, p. 21; McIntosh 1993, pp. 5-6. It appears that

The Foucauldian scholar Alexander Butchart, in his analysis of medical missionary texts of the nineteenth century, has argued that it was in the 1840s and the 1850s that "it became possible to speak freely of the African with a soul and a body that could be somehow be impacted upon by the practice of medicine".[34] As his key sources in this respect are the writings of EMMS activists, his arguments are especially relevant here. Regardless of whether a historian of ideas shares Butchart's concern with "mutations in the anatomy of power", it is clear that during this period the connection between the bodies and souls of the heathen was frequently used to justify medical mission work. Butchart is concerned exclusively with representations of the African body, but the argument that the African body enjoyed special status in early medical mission discourse can be disputed.

Butchart's outline of "moral sanitation and the medical missionary method" is based on two key texts from the mid-nineteenth century written by advocates of medical missions in Scotland. The first, *Medical Missions: an address to the students* (1849) was written by James Miller (professor of surgery at Edinburgh and a director of the EMMS); the second text is taken from W. Burns Thomson's 1854 prize essay, *Medical Missions* (1854). Both Miller and Thomson were both certainly influential medical missionary writers, but their specific connection to Africa and African bodies is less clear. Butchart's conclusion is that Miller's text proves that by the late 1840s or early 1850s the relationship between "the interior space of anatomy and the exterior context of superstition, had now become a formalised object of medical missionary knowledge, a device to inform the gaze of the student doctor… " In other words, by the mid-nineteenth century, the connection between the heathen body and his ailments, and un-Christian practices was firmly established in the missionary mind. Butchart argues that in the case of Africans, this connection had been implicit in the earlier texts of Livingstone and Dr Fitzgerald (who was not a missionary doctor) in Southern Africa, but for him the crucial change in the production of medical missionary knowledge about the African bodies can be found in Miller's and Thomson's writings.[35]

Butchart quotes Burns Thomson's essay as evidence of the newly emerging missionary medical method of theatrical healing, which emphasised the use of patients as publicists for the medical mission.[36] If Thomson's essay is inspected more closely, however, it seems an exaggeration to claim this work as overwhelming evidence of the invention of one particular medical missionary method, as well as evidence of a new medical missionary idea of *African* bodies as objects of knowledge. The essay places considerable emphasis upon the historical roots of missionary healing, starting with the "Great Physician", Christ himself. Butchart refers to Thomson's quotation from the Bible, not a reference from contemporary medical mission practice. When Thomson wrote

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Laws had first decided to become a missionary, and later an ordained medical missionary, but both decisions were made by the time he was fifteen.

34 Butchart 1998, p. 76.

35 Ibid., p. 78.

36 Ibid., p. 79, Thomson 1854, pp. 21-22.

his essay, he was just beginning his medical studies. He came from a home mission background in Edinburgh, where he experienced strong resistance to proselytisation. According to Olive Checkland, Thomson was inspired to take up medical mission work after witnessing a dramatic change in the attitudes of an unwelcoming Edinburgh family after he offered them castor oil as medicine.[37] Thus, in Thomson's work we find more contemporary references to medical mission work, notably at home among Irish settlers and "the degraded masses of our own countrymen". The overseas examples are taken from India, where medical missions had been established for some time before those in Africa. Medical missions during the nineteenth century were frequently used as the "heavy artillery of the missionary army" in the less responsive mission fields: in India, in Islamic societies and above all in China.[38] There were hardly any medical missions in Africa in the mid-nineteenth century, and the few Western doctors in Southern Africa, including Livingstone, Fitzgerald and Henry Callaway, were notably more tolerant in their attitudes towards African healing practices than their followers.[39]

In his description of medical missionary practice and methods, Thomson advocates not only open medical mission theatre based on spectacular displays of medical power, but also private approaches based on intimate treatment and conversation, which would help a medical missionary to build relationships with mothers and, through them, their children.[40] Among the various examples of overseas medical mission work, Thomson makes only passing reference to Africa, with which he obviously is not familiar. "Africans" specifically are not discussed at all. He is thus throughout the work referring to the bodies of the "heathen", whether Scottish, Irish, Indian, Polynesian, Chinese or African. It can be argued that Thomson's work is not so much valid evidence of the emergence of a specific African body as a variation of a generic medical-religious thought that has older roots than Butchart recognises. Sin and sickness have been associated in Christian thought for a long time, and in both Europe and the United States it was widely believed that epidemics, such as the cholera epidemics of 1830s and 1840s, were connected to the moral and social condition of the poor, intemperance and sexual promiscuity.[41]

That the connection between sin and sickness lay at the heart of nineteenth-century medical mission theory can hardly be doubted. In 1859, Dr David Brodie, writing his book, *The Healing Art. The Right Hand of the Church,* under the pseudonym "Therapeutes", described this connection:

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37 Checkland 1980, p. 81.

38 Walls 1982, pp. 289-290. For Indian medical missions, see, for example, *Quarterly Missionary Paper,* (Free Church of Scotland), No. XXXVI, September 1868, pp. 1-4.

39 Etherington 1987, pp. 77-9; Gordon 2001, pp. 165-184; Hokkanen 2004.

40 Burns Thomson 1854, pp. 17-25. This is clearly a disciplinary approach rather than a punitive spectacle, and it is strange that a Foucauldian approach such as Butchart's neglects this aspect of Thomson's work.

41 See, for example, Porter 1997, pp. 84-88, 122. Leprosy in particular had been a classic disease associated with sin in medieval Christian thought. Mort 2000, pp. 11-15, 24-26. See also Sontag 1978.

> The ailments of the body are closely connected with those of the soul; and even if, in individual cases, this cannot be proved, yet, in the whole progress of human development there is always a causal connection between **sin** and **evil** – between the disorganisation of the spirit through sin, and all forms of bodily disorder...Some of these diseases, also, arose purely from moral causes, and could be thoroughly cured only by moral and spiritual remedies.[42]

In the Victorian era, perhaps the best example of such a "moral disease" was syphilis, a disease that could not be treated effectively without injurious side effects until the early twentieth century.[43] From the Christian point of view, the only way to remain healthy in this respect was to stay "moral" and avoid sexual intercourse outside "pure Christian marriage", particularly with prostitutes.

Medical missionary theory not only explicitly emphasised the analysis of the body of the sinner, but also the wholeness of a person with both a body and a soul. Thomson quotes a Dr Wilson: *"The physician's patients… are not bodies, but men; and as such he must treat them… Man is a unity, and must be treated as such."*[44] Here is evidence of a rather different line of thought from the divisive, analytical, clinical gaze that creates individual bodies as objects, and this idea runs through much of nineteenth-century medical missionary thought. For Professor James Miller, there was no doubt where the primary importance of medical mission work lay: *"How blessed is that skill which cures the ulcerous wound, and mitigates the agonies of the fell disease! – but how far more blessed, to heal the soul's deadly hurt, and pour 'the balm of Gilead' into the sinner's wounded spirit!"*[45]

The late nineteenth and early twentieth century medical missionary, who combined the roles of healer of the body and of the soul, could seem somewhat anachronistic at a time of increasing medical professionalization. Smylie has argued, in his discussion of medicine in the Presbyterian and Reformed religious traditions, that while the nineteenth-century Calvinists attempted to deal with the wholeness of the person they also contributed to a division between the physician and the pastor by tending to divide the body and the spirit theologically. Furthermore, the Reformist emphasis upon the validity of vocations in God's sight may have contributed to the professionalization process.[46]

In a corresponding development, in early Victorian Scotland the Presbyterian clergy had increasingly become religious specialists within local communities.[47] In this light, the medical missionary could be seen as continuing the tradition of the Presbyterian physician-pastors of the eighteenth and early nineteenth centuries, in addition to providing an alternative model for a specialised minister. After working at the Glasgow Medical Mission and the Fever Hospitals, Robert Laws was dissatisfied with his theoretical theology lessons, stating: *"More than once I have been on the eve of throwing the Hall to the*

42 Therapeutes 1859, pp. 270-271.
43 Porter 1997, pp. 451-452.
44 Thomson 1854, pp. 37-38.
45 Miller, quoted in Lowe 1886, p. 273.
46 Smylie 1986, p. 216.
47 Cheyne 1983, pp. 110-11.

winds and sticking to my medicine alone, which gives me scope enough for preaching."[48] For his part, J.B. Russell, Glasgow's first medical officer, and an active Christian, utilised medical missionary language in domestic public health initiatives, calling for the church to help in medical and health reforms as expressions of practical Christianity.[49]

As conflicts increased between religion and science within Western universities, the foreign mission field was one area where Christian doctors could combine their professional interests and religious values in a fruitful way. Medicine, in the Presbyterian tradition, could be regarded as a "doxological science", a scientific way of glorifying God, and arguably, this was the view of Laws and many other late nineteenth-century Scottish medical missionaries. Alternatively, some Presbyterians became sceptics as a result of their medical education. Arthur Conan Doyle, a student contemporary of Livingstonia doctors, rejected the "old ironclad unreasoning Evangelicalism" and turned to agnosticism as a result of his training in "the school of medical materialism".[50]

The new profession of medical missionary found supporters among wealthy Scottish evangelicals with an interest in medicine. The EMMS initiatives encouraged medical mission work in Glasgow and Aberdeen, from where the majority of the Livingstonia Mission doctors during the 1870s and 1880s were recruited. In Glasgow, Dr Joshua Paterson founded a scholarship for a student who would take a full course in medicine at Glasgow University and a partial course in theology at the Free Church Hall, and who would commit himself to mission work after graduation. Although for Paterson medicine was the "handmaid of Christianity", he also emphasised the necessity of professional qualifications for the medical missionary. The first graduate of the Paterson scholarship was William Black, a former student of architecture, who was nominated to be the first medical missionary employed at the Livingstonia Mission: he enthusiastically supported and campaigned for the mission while finishing his studies.[51] Black introduced Laws to Stewart, who was in charge of the Livingstonia scheme, as a substitute for him (Black) in the pioneer party. Laws, in turn, promoted the Livingstonia project at Aberdeen University and the YMCA, where he attracted the attention of another key future Livingstonia doctor, Walter Elmslie (1856–1935). The recruitment of pioneer missionaries followed an apprentice–master pattern: Livingstone was the role model for Stewart and encouraged his medical studies, and Stewart in turn recruited Black and suggested that Elmslie (a young evangelist in the service of North-East Coast Mission) should study medicine in order to be a more effective agent in the foreign fields.[52]

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48 Quoted in Livingstone 1921, p. 34.

49 Robertson 1998, p. 208: Russell's "Life in One Room", lecture delivered to the Park Parish Literary Institute, Glasgow, 27 February 1888.

50 Smylie 1986, pp. 217-218; Brantlinger 1988, p. 250, quoting Conan Doyle 1924, p. 77.

51 *FCSMR,* June 1876, pp. 146-147 and October 1877, pp. 247-248; Checkland 1980, pp. 82-84.

52 Livingstone 1921, pp. 37-38, 45; Wells 1909, pp. 21-100, 127-128; for Elmslie, see *The Record,* May 1925.

At a time when medical mission advocates were arguing for the professionalization of the medical missionary, the reality in many mission fields was that non-medical missionaries often took on the role of healer, practising medicine with varying degrees of success, and were consistently recognised as healers by the indigenous population. At the Liverpool Conference of Missions in 1860, Dr Macgovan argued that although among those *"low in civilization"*, a minister might well *"very usefully blend the duties of a physician with his ministrations"*, but that in China or Japan that this would *"spoil a divine, and make a quack"*. In Africa, however, lay missionary medicine flourished at least until the end of the century.[53]

Perhaps the first medically qualified missionary in Africa was Johannes Theodorus van der Kemp (1748-1811), but whether he practised medicine in the mission field is not clear. Livingstone was arguably the first practising missionary with medical qualifications in Southern Africa, but his father-in-law, Robert Moffat, had been one of the layman missionary healers of the early Victorian period. To some extent, the role of laymen healers was recognised in 1873, when the Livingstone Training College was founded in London to provide medical courses to future missionaries. Where there was a qualified medical missionary within reach, the amateurs would give up their practice. By the early twentieth century, professionalism had taken hold in the African missions to such a degree that layman missionaries withdrew from more challenging medical practice, partly for fear of being charged with quackery.[54]

By the time the first Livingstonia party sailed in 1875, the position of medical missionaries in the Scottish mission schemes was still not entirely clear. It is perhaps significant that Laws originally came from the United Presbyterian Church. In comparison with the Free Church, the UP Church was apparently more receptive to the idea of an independent medical mission in the 1870s and 1880s. Dugald Christie, who was Laws' contemporary from the Free Church, initially wanted to join its missions in Africa, but after hearing from a colleague in South Africa who bemoaned the lack of medical resources, Christie insisted that he should be appointed as a professional medical expert, with the necessary equipment and the prospect of a hospital before his appointment. As the Free Church did not meet his demands, Christie went to Manchuria in 1882 as a pioneer medical missionary for the UP Church, which allowed him considerable freedom and were supportive of his work.[55] Seven years earlier, Laws had done the reverse: he had joined the Free Church pioneer expedition on a temporary basis, as no suitable Free Church candidate was available at the time. Unlike Christie, however, Laws was also a theologically-educated ordained minister, and his medical profession was probably regarded as being

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As Black had not completed his training while the first Livingstonia party sailed, he only joined the mission in 1876. He died of fever just seven months after his arrival. Black, Laws and Macklin of the Blantyre mission all knew each other in Glasgow.

53 *Conference on Missions held in 1860 at Liverpool.* London 1860, pp. 275-276; Gelfand 1988, pp. 23-24; Hastings 1994, p. 275.

54 Gelfand 1984, pp. 31-32; 1988, pp. 23-24; Walls 1982, pp. 291-297. However, see Comaroff and Comaroff 1997, pp. 325-326.

55 Christie 1932, pp. 26-27.

secondary and supplementary to his theological duties, by some. When the Livingstonia Mission Committee first outlined the role of the mission, its aims were classified as evangelistic, educational and industrial, not medical. On the other hand, Laws was the designated medical officer of the pioneer party, with clearly defined medical and scientific duties. It is also significant that when Laws, as head of Livingstonia Mission, described his policies, medicine was included on an equal footing with evangelisation, education and industrial work.[56] There is little doubt that Laws, himself, placed a high value on his own medical qualifications.

3.3 Evangelicalism, humanitarianism, evolutionism and imperialism

The early ideas and plans to "regenerate" Africa owed much to the humanitarian anti-slavery movement as well as to the evangelical revival. In 1789, William Wilberforce had called for legitimate commerce to replace the slave trade in Africa. Legitimate trade would, through divine providence, succeed the slave trade and in the process provide material rewards to the righteous traders. In subscribing to this combination of commerce and Christianity, a slogan to be most closely associated with Livingstone, the evangelicals followed the traditions of the Enlightenment, seeing no contradictions between theology, economics and politics. Commerce was, it was generally accepted, an instrument of God's providence. Sound commerce would promote liberty and true religion, and true Christianity alone would ensure health and happiness in society.[57] Hostility to slavery remained a central feature of the evangelical movement, which in part explains the strong interest in the missionary work in East and Central Africa, where the slave trade seemed to reign supreme. Livingstone's plans for the "regeneration" of Africa through commerce were based on the optimistic and idealistic assumption that Western traders and settlers in Africa would be "Christian", honest, upright, benevolent and progressive.[58]

Although the fight against the slave trade was a salient feature of mission ideology and action in Africa, the attack on idolatry and false gods, an older Christian objective, remained a central concern. A primary objective of the Protestant evangelical missionary movement was the crusade against idolatry, of which all religions apart from Protestant Christianity seemed to be guilty. The intellectual background of this crusade was to be found in a particular interpretation of the Old Testament, together with a theory of the historical development of religion, established in the eighteenth century. Drawing from

56 *Report on Foreign Missions for 1876*, p. 12. Medical Report for 1876–1877, Cape Maclear Journal 1875–1876, NLS, MS. 7908.
57 Stanley 1990, pp. 70-73.
58 Bebbington 1999, p. 22; Cairns 1965, pp. 192-199.

biblical evidence, some scholars argued that all mankind derived from a common origin, but after the Tower of Babel, they had scattered across the globe. The farther they wandered, the more their forms of religion became corrupt and degenerated into pagan idolatry in contrast to the original, pure revealed religion. Thus, the missionary objective was to "re-generate" the heathen and bring him back into the fold of the Lord. In the case of Africans, the early modern Europeans had put forth a "Hamitic Hypothesis" of their origin: Africans were descendants of the cursed Ham. Although these ideas and theories were increasingly contested (for evangelicals, Christ had removed all curses) and later abandoned as the nineteenth century wore on, the idea of "regenerating Africa" remained, taking on new forms and connotations as evolutionary theory impacted upon natural science, social theory, medicine and theology. [59]

It has been argued that in the history of nineteenth-century Scottish Presbyterian Churches, Darwinism had a more profound impact than the Disruption. The idea of evolutionary advance was well-suited to the progressive, optimistic mid-Victorian frame of mind. However, within the new evolutionary paradigm, an idea of evolutionary regression or degeneration was also introduced into scientific and medical thought. Daniel Pick has argued that this language of degeneration increasingly influenced wide segments of culture in the late nineteenth and early twentieth centuries. In European attitudes towards Africans (and most other non-Europeans), evolutionary theory gave a new "scientific" boost to the old ideas of a linear progression from savagery to civilization. As V.Y. Mudimbe has pointed out, Enlightenment discussions of Africa and Africans had been part of series of oppositions and classification of humans, required by "the logic of the chain of being", and its stages of process and development. While Africans had earlier represented "savagery" in comparison to the "civilization" of Europeans, the difference was now increasingly understood in terms of evolutionary biology and social theory.[60] In the age of the New Imperialism and social Darwinism, in the words of Mudimbe, "evolution, conquest, and difference became signs of a theological, biological and anthropological destiny, and assign to things and beings both their natural slots and social mission."[61]

The scientific model of degeneration, popularised by the zoologist E.R. Lankester, was in some ways acceptable within religious circles, because it could be seen to correspond to the earlier, religious model of the fall of Man[62] and in particular the fall of the pagans. Nevertheless, reconciling a Christian world-view with evolutionary theory was far more difficult than it had been with early nineteenth-century natural history. Many Scottish churchmen and scientists grappled with these issues. One of the most well known in his time was Professor Henry Drummond (1851–97), a Free Church preacher, natural

59 Stanley 1990, p. 64; Interview with Professor Walls, December 2002.

60 Cairns 1965, p. 89; Drummond and Bulloch 1974, p. 299, Mudimbe 1988, pp. 12-13; Pick 1989, pp. 5, 20. See also Curtin 1964; Hammond and Jablow 1970.

61 Mudimbe 1988, p. 17.

62 Pick 1989, pp. 216-217.

scientist, explorer and a major influence behind the Student Volunteer Movement in Scottish universities.[63] Although Drummond was not a prominent figure in many of the rapid changes occurring in Scottish religious thinking during the last quarter of the nineteenth century, A.C. Cheyne has argued that because of Drummond's great sensitivity to the intellectual and spiritual currents of his time, his attitudes, speeches and writings frequently mirrored the central concerns and convictions of late Victorian Scottish Presbyterian intellectuals.[64] In the discussions regarding evangelicalism and science, as well as in student missionary circles, Drummond was a prominent and substantial figure.

Drawing on the works of Darwin, T.H. Huxley, Lankester, and above all Herbert Spencer, Drummond attempted to reconcile evolutionary theory with Christian doctrines by applying the concepts of natural science to the spiritual realm. In his best-selling book, *Natural Law in the Spiritual World* (1883), Drummond defined life as the total of functions resisting death. Analogically, spiritual life was the total of functions resisting sin. In both the physical and spiritual spheres, Man faced a choice between "Balance", "Evolution" and "Degeneration", and in the long run, the only escape from the ultimate degeneration and the destruction of the soul was through the gradual evolution to higher being.[65] Salvation was thus possible only through a process of natural growth in Christian principle, which was an idea familiar to the evangelical doctrine of spiritual regeneration. For Drummond, a Christian was *"an organism, in the centre of which is planted by the living God a living germ."*[66]

The words "planted" and "germ" are significant here. As David Bebbington has pointed out, *Natural Law* deals not with science in general, but concentrates exclusively on biological processes. Biology was the scientific discipline most familiar to Drummond, who had been familiar with botanical nurture and classification work from his childhood. Drummond's choice of the biological language of growth seems to highlight the romantic element in Drummond's thinking. A tree or a flower was a prominent metaphor of the Romantic Age. In contrast to the mechanical metaphors of the Enlightenment, Romantics saw human beings and societies in terms of growing and developing organisms. The pre-eminence of the motif of growth can be seen, in part, to explain why Drummond understood conversion as a process, the result of gradual development, rather than a sudden transformation.[67] The terminology of agriculture and biology had a lasting currency in medical as well as missionary language. "Planting the seed" had been a favourite biblical metaphor for many missionaries, especially when their work was progressing

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63 On Drummond, see the essays in Corts (ed.) 1999.

64 Cheyne 1999, p. 4. In Uganda, the CMS missionary Alexander Mackay sent Emin Pasha, a naturalist, a copy of *Natural Law* in the hope it would "open his eyes". See Stock 1899, p. 422.

65 Drummond 1884, pp. 101-104, 117; Bebbington 1999, pp. 33-35.

66 Drummond 1884, p. 128.

67 Bebbington 1999, pp. 30-35.

slowly.[68] After the seed has been planted, it must be protected and nourished, and, of course, the growing plant has to be kept free from disease. As Worboys has noted, "in Britain the dominant metaphor in germ theories of disease and health was the botanical one of 'seed and soil'. In many cases, this was literally true. Bacteria was classified as plants, as were other likely pathogenic organisms, for example, fungi and fern spores."[69]

When Drummond wrote about planting the germ of (spiritual) soul in the Christian (biological) organism, he repeated an old theme, but in a significantly novel way. For him, this process, which occurred in the spiritual realm, was thoroughly *natural*, as understood by evolutionary biology. The language used by Scottish missionaries in the late Victorian period, especially those who had studied medicine, would be strongly informed by terminology of degeneration and regeneration common to biological, medical, sociological and theological language.

In 1877, after taking up a lectureship in natural science at the Free Church College, Glasgow, Drummond continued to conduct weekend meetings for students in Edinburgh until his death. Although he never completed his degree after studying mathematics, physics, botany, chemistry, zoology and geology, as well as theology, he did possess some standing as a practising scientist, conducting experiments and taking part in scientific expeditions to Canada, Central Africa and Australia. Bebbington has argued that it was partly because of his scientific reputation – though in reality Drummond was a gentleman amateur in most sciences – that he exerted a special influence over medical students in Edinburgh, a group who had previously been noted for their boisterous behaviour. This group of students included several future medical missionaries to Central Africa.[70] Drummond was also directly involved with the Livingstonia Mission. He was sent by James Stevenson to conduct a scientific exploration of the Lake Malawi region in 1883 on behalf of the African Lakes Company. He visited the mission and spent some time at the Bandawe station, where he met with Laws. Subsequently he was elected to the Livingstonia Sub-Committee, as well as to the Board of the ALC.[71]

Although Drummond was hugely popular in his time, not all Presbyterian theologians or scientists shared his views. His later work, *Ascent of Man,* was heavily criticised by scientists and theologians alike. Bebbington has argued that Drummond may well have failed to convince his more discerning readers, and emphasised that his particular blend of Christianity and evolutionary

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68 For a recent study of natural history, science and British evangelical missionaries, see Sivasundaram 2005.

69 Worboys 2000a, pp. 7-8.

70 Bebbington 1999, pp. 31-32. Among those Free Church Livingstonia doctors who could have met with Drummond during their student days were William Scott, David Kerr Cross, George Steele, David Fotheringham (all Glasgow graduates between 1880 and 1890), George Prentice, J.C. Ramsay and A.W. Roby-Fletcher (Edinburgh students in the early 1890s).

71 Livingstone 1921, pp. 212-219; Moir 1924, p. 8; Scott 1985, p. 49. According to Livingstone, Laws "fell under the spell" of Drummond's charming personality and requested that Drummond be given a seat on the Home Committee.

theory was not the only or most satisfactory one.[72] Nevertheless, it is argued here that his ideas and concerns are crucial to understanding the intellectual context in which the Scottish missionaries of the late nineteenth century, and especially the university-educated missionaries, must be placed. The relationship between the Christian world-view and evolutionary theory, or religion and science, however, was not the only or the most pertinent issue for missionary thinkers and activists of the late Victorian age. Arguably, a more important and older question concerned the fate of the pagan soul.

What would happen to the souls of those heathens who died before hearing God's word? This was a question of paramount importance to nineteenth-century missionary activists. For many, including Robert Moffat, an early Scottish LMS missionary in South Africa, who ultimately relied on strict biblical interpretation, the answer was simple: they would be doomed to Hell and eternal damnation. Moffat's son-in-law, David Livingstone, shared this view during the early stage of his career, but by 1851 after watching the funeral of an African chief, he admitted that he had no answer as to the ultimate fate of the heathen. Henry Venn, the predominant English missionary theorist of the mid-Victorian period, concluded in 1850 that those who die before hearing God's word would not be punished in the same manner as those who heard and rejected the word. Explicit references to an eternity of hellfire are rare in the pioneer Central African missionary writings. However, the matter remained controversial throughout the Victorian age, and the idea that millions of heathen all over the world were dying because they had no chance to hear the Word continued to give a raw urgency to the missionary cause, making the mission of saving souls more important than the other aims of the missionary project. In 1905, Livingstonia nurse and teacher Jessie Fiddes wrote after witnessing the death of a "heathen" man: "*I stood transfixed for nearly half-an-hour afterwards, wondering where the man's soul had gone to. I am nearly overpowered by the utter darkness and indifference.*"[73]

By the early twentieth century, a liberal Protestant missiology that emphasised fulfilment rather than judgment in the relationships between Christianity and other religions began to gain ground and replace the older doctrines. However, Stanley has argued that throughout the high imperial period (c. 1880–1920) those who did not share the conviction that the heathen who had not heard the Word were doomed to perish, found an alternative rationale mainly in the dissemination of the benefits of the Western civilization[74], medicine among them. Medicine could be seen as a useful missionary tool in any case: keeping the heathen alive longer through medical treatment would give a missionary more time to deliver his soul-saving

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72 Bebbington 1999, p. 38. For a satirical critique of Drummond, see Carswell 1927. Of Livingstonia doctors, Elmslie in 1890 held that Drummond was "a humbug but a slashing swell". McCracken 2000, footnote 41.

73 Excerpt of Fiddes to Barr 31 August 1905. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1905, p. 83. Also quoted in Forster 2003, p. 12; Cairns 1965, p. 202; Stanley 1990, pp. 65-67.

74 Stanley 1990, pp. 65-67.

message effectively, both at home and in the foreign mission field. Robert Laws described his work as a missionary ("a priest of death" in his own words) in the Smallpox and Fever Hospitals of Glasgow:

> Those dying of fever I can seldom converse with, as they are generally unconscious; but in the majority of cases of smallpox, there is an interval of consciousness between the period of delirium and the time of death. Often during that season the real state of the individual God-ward is revealed.[75]

Walls has pointed out that during the 1880s and 1890s a humanitarian motive was most frequently put forward as a justification for medical mission work, and it was "urged by and upon the same constituency as was moved by calculations of the numbers of heathen passing annually into a Christless eternity."[76]

The sometimes complex discussion regarding the fate of the heathen is highlighted by following case. While training for the Central African mission field as an ordained medical missionary for the Blantyre Mission, W.A. Scott was deeply disturbed to read an article by Archdeacon F.W. Farrar, and attacked "with scorn" Farrar's "dangerous teachings" in his home mission class. What these ideas were is not explicitly clear from Scott's biography; however, Farrar's essay *The Wider Hope* (published in 1890) may provide some clues about Farrar's teachings. In this text, as well as in some of his earlier writings, Archdeacon Farrar attacked what he saw as the reign of fear and terror in much of contemporary preaching. He argued that redemption was possible between death and doom as well during life, and that faith could be acquired after death.[77] Such a doctrine would seem problematic, if not dangerous, for a mission enthusiast at home or abroad, because if salvation after death is possible, even probable, why concentrate so much upon saving souls during life? This case seems to suggest that Scott, for one, strongly believed that hope of salvation existed only in life, and that death for an unrepentant sinner must mean damnation.

Archdeacon Farrar's thinking can also be juxtaposed with that of missionary activists' in other respects. In 1867, Farrar, then a Harrow schoolmaster as well as clergyman-writer and armchair-ethnographer, argued, at a meeting of the Ethnographical Society of London, that the extinction of inferior races such as the "degenerate negro race" of Africa was inevitable. For Farrar, all that Christians could do was to look after the dying races with Christian compassion before their end. Farrar, a friend and pall-bearer of Darwin, had missionary connections especially to the CMS,[78] but his social Darwinist thinking seems to be completely opposed to the justification of "regenerating" missionary activity, except as a form of Christian sympathy for

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75 Laws, quoted in McIntosh 1993, p. 11.
76 Walls 1982, pp. 288-289.
77 Rankine 1896, pp. 57-58; Farrar 1890, *passim.*
78 Farrar 1867, pp. 116-126, also quoted in Biddiss 1979, pp. 150-151 and Mangan 1987b, p. 149; *Dictionary of National Biography, supplement for 1908*.

the dying. What he believed would happen to the souls of the members of "degenerate races" after their demise is unclear, however.

Such ideas, which saw the native races doomed to extinction, as put forth by men like Farrar and Karl Pearson (a socialist, mathematician and eugenicist)[79], demanded a response from missionary activists, in defence of the indigenes as well as a justification of the missionary enterprise. Cairns has noted, however, that on the whole, social Darwinist ideas in the discussion of race relations, or as a justification of imperial control in nineteenth-century Central Africa were surprisingly uncommon particularly when compared with the influence of social Darwinism upon European views of American Indians or Australian Aborigines. The high mortality and morbidity rates among European pioneers in Central Africa made the idea of Europeans as the fittest survivors and Africans as perishing natives seem dubious, if not untenable. Accordingly, European theories of colonial occupation and rule were based on the assumption that Africans would survive and play a permanent role in the future economic development of the colonies. Those theories that justified the decline of the African race lacked utility as well as credibility.[80] However, there were a number of influential late Victorian and Edwardian commentators on Africa who did not question African survival, but who did have reservations about the Christian conversion of Africa.

In opposition to missionary views of racial evolution caused or accelerated by Christianity, atheistic or agnostic Victorians, including Richard Burton, had argued that religion was a "mental expression of a race", and that Christianity as a superior religion would be suitable only to the superior races. For his part, Samuel Baker, a contemporary of Livingstone and an uninhibited advocate of harsh racial doctrines in Africa, believed in a climatic theory of history, arguing that human intelligence, power and energy were all dependant on climate. Climate dictated the natural "energy" of a country and its people, and "energy" determined its civilization. For Baker, the English were always energetic civilized rulers, and Africans were destined to savagery and servitude. More intellectually sophisticated advocates of cultural relativism argued that Islam, not Christianity, was the religious force best equipped to regenerate Africa. For many of the British proponents of Islam in Africa, it was a question of race and biology: for them, Christianity belonged exclusively to the progressive, "Aryan races". In 1887, Canon Isaac Taylor, an Anglican churchman, sparked furious controversy when he claimed that Islam had done more for civilization in Africa than Christianity. Taylor based his arguments on racial theory, claiming that it was all a question of "cerebral development". In his view, racial physiological and anatomical differences dictated that "higher religions" were for the "higher races", and Islam was the suitable civilizing and elevating religion for African "cannibals".[81]

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79 Pick 1989, pp. 199-200.
80 Cairns 1965, pp. 237-238.
81 Cairns 1965, pp. 203-212.

James Stewart, founder of Livingstonia and long-time leader of the South African Lovedale Institution, addressed these issues when he gave the 1902 Duff Lectures in Scotland, and presented his views of the past, present and future of Africa and the African people. Stewart observed that in the struggle of nations, the African races seemed to be lagging, if not completely left behind. The main reason for this, he argued, was their lack of advanced religion and moral "vitality". Without advanced religion, there were no "moral forces" – for Stewart, the main means of racial advancement – and he warned of *"...descent into mere animalism and fixed and hopeless barbarism."* Islam could not be an alternative to Christianity as Stewart held that it always led to despotism, denigration of women and the promotion of slavery.[82]

According to Stewart, the degeneration of Africa was mainly due to practices such as polygamy and witchcraft that were not only violations against the Bible, but were "unnatural" violations of nature's laws. This degenerative process was reversible, however, through the external help of the missions. The process of regeneration began through *"...the planting of Christian moral ideas, which will then grow and stop the unnatural customs".* For both mental faculties and muscular power, the keywords of regeneration were *"vitality, activity and growth."* To stand still was for Stewart, as for Drummond, the beginning of retrogression, *"atrophy being the penalty of non-activity or disuse."*[83]

Stewart, an optimistic missionary, argued strongly against all claims that the Africans were doomed to extinction, continuing in the tradition of Livingstone, who had described Africans as "suffering" but not "perishing". He drew on the history of the Jews and the Britons to prove how "the fortunes of race" change. For Stewart, who was influenced by Benjamin Kidd, evolution was above all social and moral, rather than biological and physical. He believed that evolution in the moral and spiritual realm could progress far more quickly than the merely physical, although spirit, morality and the body were all interconnected. Therefore, moral regeneration through the gospel of Christ, the promotion of a Calvinist work ethic and legitimate commerce could produce substantial progress within a relatively short time. A proper missionary education, which would not act as a "retarding influence" on educated Africans, was a justified, successful and righteous enterprise. Stewart asserted that true Christianity would never cause anything degenerative. He argued that the European atrocities in the Congo, for example, while degenerative of character, were the work of false Christians.[84]

Stewart's apologia for mission activity in Africa synthesised several familiar threads of Victorian Scottish evangelical thought: the Enlightenment idea of the importance of legitimate commerce, the Presbyterian emphasis on a work ethic as the main regenerative force for Africa and the nature of Christian mission work as planting and protecting the seed in the spiritual realm. Like Alexander Duff, Stewart believed that in due course Christian education would

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82 Stewart 1903, p. 14; Wells 1909, pp. 258-259. See also Porter 2004, p. 216.
83 Stewart 1903, pp. 294-299.
84 Ibid. pp. 311, 361-371; Cairns 1965, pp. 192-199; Wells 1909, p. 259-260.

raise African society to a more elevated state, obeying both the laws of the Bible and of nature, between which he saw no contradictions. Like Drummond, he emphasised the importance of growth, and the placing of the spiritual above the physical although insisting on an analogous and interconnected development. Unlike Drummond, however, he stressed the fact that evolution in the moral and social realm could progress more rapidly than in the physical world. By this, Stewart seemed to allow the Africans a chance of salvation whilst, at the same time, he implicitly suggested that they might be racially inferior to the Europeans, both physically and biologically.[85] As Cairns has noted, for the late Victorian commentators on Africa and Africans, "the now discarded idea of race constituted a basic element of confusion with its implication of the fixity, or at best slowly changing, nature of cultural traits."[86] While fundamentally disagreeing with the Western commentators who saw Africans either as perishing or as "racially" and biologically unsuitable for Christianity, Stewart shared with them the discourse of race and evolution in his discussion of society and culture.

In the late nineteenth century, while European powers colonized and divided almost all of tropical Africa, a prominent European analogy represented Africans as child-like. This analogy was supported by a number of attributes seen to be common to both a European child and an African adult: emotionalism, a lack of a sense of time, space or truth and an absence of forethought. The "incomprehensible" African thought processes were, it was claimed, further proof of Africans' mental immaturity. As Cairns has noted, the child analogy, which conveniently justified colonial occupation, was consistent with the idea of Africans as "contemporary ancestors" or comparable to the lower classes in Britain. Like children or the working classes, Africans were in need of civilized, superior and controlled paternal upper- and middle-class white rule. The child analogy made African self-rule an impossibility, and humanitarian concern for the protection of Africans from the slave trade, the Arabs and the Portuguese (who for British were agents of destruction rather than civilization) justified the humanitarian case for imperialism. The belief was genuinely held by many of the British but was cynically exploited by others, for whom the humanitarian arguments provided useful cover for violent conquest and economic exploitation in Central and East Africa. Referring to African men, regardless of age, as "boys" was an everyday manifestation of colonial attitudes and mentality. This practice was generally adopted by missionaries and secular colonialists alike, and was disliked intensely by senior African Christians in Livingstonia. As Thomas has noted, the nineteenth- and early twentieth-century missionary project did not portray the indigenous people as masculine or

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85 Stewart held that "race" had "something to do" with Western "progress", but "neither race nor evolution", without accounting for Christianity, sufficiently explained the superiority of Western civilization. Stewart 1903, pp. 34-35.

86 Cairns 1965, p. 192.

feminine but as infants in a state from which Christian men and women were to emerge under missionary guidance.[87]

Colonial medical theory, especially psychiatry, contributed to and developed this discourse further. In the early twentieth century, European colonialists increasingly emphasised the perceived African biological, as well as cultural, inferiority. Colonial doctors were a prominent group who stressed the lack of "moral fibre" in Africans thus legitimising the colonial rule. Colonial psychiatry provided images and constructions of the "African" as a biologically determined "other" at the turn of the century.[88]

Arguably, the missionary emphasis on the spiritual over the physical, and the significance of sin, the gospel and salvation equally to all men, could check the "scientific" racialist thought in the missionary mind. However, the late Victorian and Edwardian medical missionaries in particular had to grapple with these intellectual issues in an attempt to combine their faith and mission with their medico-scientific education. In turn, secular colonial doctors and psychiatrists often directly or indirectly blamed the missions for the creation of "decultured" Africans: people afflicted with a mental disorder as a result of being uprooted from their traditional, "untouched" way of life.[89]

In his foreword to the biography of fellow missionary and friend Dan Crawford, the aging Robert Laws addressed the issue of sin and the soul:

> Sin was to him [Crawford] a terrible reality, with its consequence of separation from God and the spiritual death which it means. With the incisive and relentless diagnosis of the disease came his application of the remedy – Jesus Christ as the only Saviour; and the individual acceptance, by faith, of Him as the sinner's personal Saviour – the conversion of the individual – as the way of salvation. There was with him and his preaching no camouflage of sin, as heredity, environment, inferiority complex, or any other of the fashionable narcotics of the conscience so much in vogue at present. To him, as to the apostles of old, sin meant death, salvation meant life, and to rouse a man to the reality of the first, and to accept the second, whenever he had the opportunity...was the mission Dan Crawford felt God had called him to fulfil. It is the message the world needs.[90]

In his eulogy for Crawford, Laws vigorously defended his own Victorian Presbyterian commitment to the primacy of saving the heathen soul, in accordance with Stewart, emphasising the moral and spiritual over the physical, cultural and psychological. It is worth noting the medical and pharmaceutical metaphors used by Laws: sin is a disease to which only individual conversion to Christ is the ultimate cure, no matter what the hereditary, cultural or psychological conditions might be. "*The fashionable narcotics of conscience*" from materialistic biology and psychology were clearly anathema to Laws.

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87 Ibid. pp. 235-237; Thomas 2000, p. 315; Copy of letter of Yesaya M. Chibambo to the Mission Council. Minutes of Mission Council, 21 July 1921. MNA 47/LIM/3/17; McCracken 2000, p. 309; MacDonald 2000, p. 107.

88 Lyons 1994, p. 211; Vaughan 1994b, pp. 174-177.

89 Vaughan 1994b, pp. 174-177; see also Vaughan 1991.

90 Laws in Tilsey 1929, p. vi.

The roles played by missionaries in imperial and colonial projects are a source of significant ongoing debate, and are beyond the scope of this enquiry. However, it should be noted that –despite their stance against the doctrine of racial inferiority that portrayed Africans as perishing and their criticism of what they regarded as the degenerative and destructive deeds of Arabs, Portuguese and (on occasion) British colonialists – the late Victorian missionaries in Central Africa were by implication, by analogy and (in some cases) directly associated with imperial conquest. In the 1860s, Livingstone, Stewart and Horace Waller entertained imperialist ideas and the pioneer Scottish missionaries in Blantyre and Livingstonia a decade later became, for a while, temporal rulers themselves, albeit only on a small scale. British missionaries in the 1880s consistently encouraged the extension of British imperial control although after the occupation, they often became the most vocal European critics of both the administration and the secular settlers.[91]

3.4 Self-sacrificing heroes of religion and science: the recruits to Central Africa – Image, self-image and motives

J.P. Goubert has pointed out that when analysing the motives and incentives of healers, a historian should pay attention to the rewards, both material and spiritual, that they expected to receive for their services.[92] The rewards, in the case of medical missionaries, should be understood broadly: not merely in terms of this-worldly gain but, more significantly, in terms of perceived benefits to the ultimate cause of the missionaries, the conversion of the heathen to Christianity, to the social group of missionaries and to the individuals themselves. Why would a medical student or nurse in late Victorian Scotland want to pursue a missionary career in Africa, in distant and alien lands where illness and death were arguably far more probable than on the home mission front or in a Scottish hospital? Traditional missionary biographies and autobiographies have explained the motivation as a call from God, often experienced in youth. How are modern scholars to interpret this experience? It may be argued that it is impossible to completely understand such an individual religious experience without having shared similar experiences, but it is possible for a historian to look for other, more general explanations in the intellectual and social conditions of the age as well as individual motives and incentives without denying that many missionaries could have been motivated by the personal and emotional experience of a direct call from God.[93]

91 Cairns 1965, pp. 238-244; Porter 2004, pp. 267-274. Cf. Wells 1909, pp. 333-334.
92 Goubert 1987, p. 43.
93 For example, Macintosh 1993, p. 5; Prentice to Smith 14 July 1892, NLS, MS. 7873, 63; For the limits of historian's interpretations regarding personal religious life, see Landau 1995, conclusion. On a more general level, see also Horton 1993, p.165.

In his innovative study of Dutch Catholic missionaries and the Waluguru in late colonial Tanganyika, Peter Pels has provided an interesting analysis of missionary motivation. Pels emphasises the concept of "sacrifice" in his approach, and he argues that in order to appreciate what the missionaries felt they had to gain from their sacrifice, it is necessary to appreciate its essential paradox. "A sacrifice mediates between human and non-human worlds through abnegation of something 'human', and thereby simultaneously establishes interpenetration of and distance between the two worlds, conjunction and disjunction. A sacrifice entails both abnegation and selfishness..."[94] Pels points out that a sacrifice for the missionary cause can be made by an individual, but also by a family sending one or more of its children into missionary service. Most importantly, Pels stresses, "it was the sacrifice *for others...*usually for Africans – that articulated the identity of the mission and Congregation as a whole" (emphasis original). This act of sacrifice was modelled after the ultimate sacrifice of Christ on the Cross, the missionaries left their families and sacrifice "all that they were and possessed" to save the people Christ had not reached.[95]

According to biographers, Laws' father had in his youth wanted to become a foreign missionary himself, but being unable to do so, had hoped his son would follow this vocation, although he did not show this explicitly. However, he told the child heroic stories of foreign missionaries and provided him with the *Children's Missionary Magazine, Monthly Record* and later biographies of Livingstone, Moffat and others. Young Robert modelled himself after Livingstone: when he had to work hard to earn money as a child, he handed his first pay over to his stepmother just as Livingstone had done. When Laws told his father that he intended to become a foreign missionary, his father struggled before giving his consent and prayed, with a broken voice, that his son would be "made an instrument of blessing to others" when he left Aberdeen. Clearly, this appears to be a case of a family sacrifice, not just the decision of an individual. Hamish McIntosh has also pointed out the influence of Miss Melville's Sunday school in Laws' and his wife's education. No less than five of her former pupils became well-known missionaries, and Laws remained in contact with Miss Melville until her death.[96]

The role and image of Christ were crucial to late nineteenth-century missionary self-image. This was true in a specific way for medical missionaries, who shared the role of healer with the Great Physician. One of the main biblical justifications for medical mission work was that Christ, Himself, had cured the bodies as well as the souls of men. When the touch of a missionary healed the body of a suffering heathen and at the same time reached for the soul, the missionary was as close to his Master as possible. As Dr Alfred Roby-Fletcher put it:

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94 Pels 1999, pp. 47-55.
95 Ibid. pp. 52-55.
96 Livingstone 1921, pp. iii, 13-30; McIntosh 1993, pp. 3-5.

> As a medical it is my special desire to let the attention given to the bodily frames of the people have a Christ-like significance, more in the spirit in which such work may be done than in the mere exhibition of cures; while at the same time one may point all, whether suffering or in good health, to the Risen Christ who in supplying the needs of the soul has no human limitations...[97]

In many ways, the preparation of Roby-Fletcher summarised elements of the late nineteenth-century missionary scene in Scotland. He had his first glimpse of foreign missionary work when he visited India with his father who was a minister and a mission enthusiast. Fletcher finished his medical training in Edinburgh, where he was the president of the Student Volunteer Union. He worked with the EMMS and lived at the Livingstone Medical Missionary Institution in Cowgate. He organised missionary lectures for Edinburgh school pupils and strove to raise interest in mission work. Fletcher planned to write a book on the philosophical aspects of the mission cause, but intended to complete it only after he had actual field experience.[98]

The image of sacrifice included a strong possibility of martyrdom. Roby-Fletcher died at Bandawe just few months after his arrival. Livingstone was perhaps the ultimate model of martyrdom, and scholars have noted how through his heroic death he became the paradoxical figure of a Protestant saint in many imaginations.[99] Pels sees martyrdom as potentially linking the symbol of sacrifice to a different realm of imagery that inspired aspiring missionaries, namely adventure in exotic lands.[100] By the last quarter of the nineteenth century, Africa had became the scene of many kinds of adventures for Europeans, as portrayed in travel literature, missionary accounts, newspapers and popular stories, whether "scientific", "religious" or "popular". Explorers, pioneer missionaries, big-game hunters and colonial soldiers were among the prominent European adventurers who were until the late nineteenth-century almost exclusively male. For the missionary women who came to prominence during this period, the foreign missionary field, notably medical practice, arguably offered their only major opportunity for adventure and allowed them to participate in many new spheres of activity that were closed or severely restricted at home.[101]

The pioneer missionaries, of whom Livingstone was undoubtedly the most important for the Scots, often combined several roles. Livingstone could be seen as a missionary, explorer, doctor and a scientist, who contributed not only to advances in geography but also to zoology, botany, ethnography and medicine. In addition, he faced wild animals, and dangerous and exotic "natives", although, unlike most of his explorer colleagues, he did not often resort to using a gun in his dealings with people. For those Scottish children and youngsters, like Stewart, or Laws (who admired Livingstone at the age of

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97 Fletcher to Smith 9 August 1897, NLS, MS. 7880, 71.
98 Ibid.
99 Mackenzie 1996, pp. 203-216; Wolffe 2000, p. 145.
100 Pels 1999. pp. 52-53.
101 Ibid., On hunting and hunting adventures, see Mackenzie 1987, p. 179. On the influence of late Victorian boys' adventures, see, for example, Jeal 1989, p. 45, Mackenzie (ed.) 1986. On missionary women, see Bowie 1993, pp. 5-7 and *passim.*

twelve), who found *Missionary Travels and Researches in South Africa* (first published in 1857) to be an inspiration, the book contained rich elements of adventure in addition to its message about the propagation of the gospel and civilization. Young Laws was particularly excited about "Livingstone's Makololo" and at one point prayed nightly, "O God, send me to the Makololo". For Stewart, then in his twenties, Livingstone's many-sidedness as a Christian, scientist, doctor and explorer was particularly appealing.[102]

In the culture of African exploration, the map of the continent was a particularly potent symbol of missionary, scientific, and imperial endeavour, as Felix Driver has noted. Paradoxically, as European knowledge of Africa increased, so too did the rhetoric about "Darkest Africa". Laws' daughter, Amelia Laws, pointed out that that her father's first contact with Africa took place at the age of fourteen when he drew a map of Africa and printed the word "UNKNOWN" across the centre of the continent.[103] When Laws was preparing to leave Scotland for the first time, he dreamed of Livingstone-like exploration. He wished to spend his career in Africa, "advancing ever into the 'regions beyond' ". Eventually, Laws became a member of the Royal Scottish Geographical Society, and was awarded a Fellowship in 1900.[104]

Missionary activists prepared the ground for recruitment by targeting children and the young in Sabbath Schools and youth organisations. In his letter to Sabbath school children in 1886, Elmslie described in a semi-autobiographical fashion a career of a "little boy" who once read the *Children's Missionary Record* and gave his pennies to the missionary cause, and was now happily teaching the heathen. He then added, *"I want you all to try and know if God is calling you to be a Missionary...if you give your hearts to Jesus now you will find it easy and pleasant to serve Him when you are grown up."*[105] For the missionary enthusiasts, the call of God was very real, but it occasionally required human encouragement and propagation, especially among the young. Dr Frank Innes, son of the manse and a member of the Aberdeen YMCA, had, like Laws, *"his heart set out on Foreign Mission Service"* since he was fourteen, according to Charles Sherriffs who testified to Innes' "spiritual fitness" for Livingstonia.[106] Women were prominent supporters of British foreign missionary activities, and raised funds, organised meetings and made clothes for African children. The first women in the foreign fields were missionary wives, but during the second half of the nineteenth century, single women were increasingly recruited as missionaries. For missionary women, both wives and as unmarried women, the idea of distinctive "women's work" among pagan women, provided a sphere of

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102 Livingstone 1921, p. 14; McIntosh 1993, p. 5; Wells 1909, p. 21. Cf. Fabian 2000, pp. 209-212.

103 Brantlinger 1988, pp. 173-198; Driver 1996, p. 115; Amelia Laws, greeting to the members of the church in Malawi, Aberdeen University Library (AUL), Laws Papers, M/Laws 3; Laws 1934, p. 5.

104 Typed extract of Laws 3 February 1875. AUL M/Laws 2; Commemorations to Laws, AUL M/Laws 3. In 1920, Laws, Elmslie and Prentice were all Fellows of Royal Geographical Society. *Report on Foreign Missions* 1920, p. 54.

105 Elmslie to "dear friends" 10 November 1886. NLS, Acc. 9220 (i), (iv).

106 Sherriffs to Smith 4 May 1899. NLS, MS. 7882, 46.

activity at home and abroad. The Christian call for duty, a commitment to charity, possibilities for self-fulfilment and notions of romance and adventure were all significant factors in the motives of missionary women, in Scotland and elsewhere.[107]

For children and the young, adventure in Africa was particularly appealing. As Dr George Prentice confessed after his early years in Central Africa, stories of adventure could influence the decision to pursue a missionary career in Africa:

> Was it not the romance of missions that brought you here? And was it not that book, Heroes of the Desert, you read at school that influenced your choice more than your deliberate judgment after fully weighing in your mind the spheres of probable usefulness?[108]

By the early 1890s, Livingstonia Mission was renowned throughout Scotland and was perceived to be a mission field that was particularly promising for adventure. The work of Livingstonia was associated with the fight against the slave trade, which had turned into a real war during the 1887–89 "Arab War" at the northern end of Lake Malawi. Missionary propagandists described the missionaries as heroes facing war, "Arab" slavers, witchcraft and superstition among fierce warrior tribes like the Ngoni. At the time, there were an increasing number of converts at Livingstonia and the mission claimed the credit for brokering a peace settlement between the Ngoni and the Tonga. Missionary doctors were portrayed in the church periodicals as peace-making diplomats and military surgeons as well as medical evangelists.[109]

The Livingstonia missionaries recognised the importance of images of adventure. In 1908, when the Mission Council discussed the new mission journal policies, they agreed that *"Current events to be dealt with in such a bright and attentive way as to compel an attention, and the romantic and adventurous side of missions to be brought into prominence."*[110] In missionary publications, stories of doctor-hunters served to attract the young Scots readers. In 1926, for example, Dr Turner described in the *Record* how he ran from his microscope "to hunt larger parasites", to shoot lions at Loudon.[111] The recurring theme of "manliness" ran through the medical missionary literature published for children from the late Victorian period until after the Second World War. This

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107 Kirkwood 1993, pp. 25-38; MacDonald 2000, pp. 104-111; Williams 1993, pp. 61-64.

108 Report on Foreign Missions, 1900, p. 99. *Heroes of the Desert. The Story of the Lives of Moffat & Livingstone,* written by Anne Manning, was a popular adventure book, history and biographical work on the two Scottish missionary pioneers in Southern Africa, first published in 1875.

109 See, for example, *FCSMR* October 1887, pp. 306-307; May 1888, p. 143; August 1888, pp. 238-239; August 1889, p. 239; Elmslie 1901; Fotheringham 1891.

110 Minutes of the Mission Council, January 1908. NLS, Acc. 7548 D 71. Letters to the Livingstonia Sub-Committee, 1908, pp. 67-68.

111 *The Record* June 1926, pp. 293-294. In the 1920s, the nurses would write, too, of the patients wounded by wild beasts. Occasionally in nurses' narratives, "a hero" – albeit a childlike hero – could be the African patient. Nurse Gilchrist from Mwenzo in 1928 recounted the story of a man who was attacked by a lion but killed it with "his little native axe" and arrived at the hospital "very excited" and left to go home after a speedy recovery "feeling quite a hero". *Reports on Foreign Missions,* 1928, p. 99.

was particularly the case in descriptions of missionary activity in Africa, in which missionaries were portrayed as "muscular Christians" with unshakeable confidence. This genre was notable for its binary oppositions: good versus bad, Christianity versus heathenism, civilization versus nature, missionary doctor versus "native patient", hospital versus "wounds of wilderness and witchcraft".[112]

For David Fotheringham, who joined the Livingstonia Mission as an ordained medical missionary in 1891 (and whose brother, an ALC agent, had fought in the Arab War), adventure, hunting and the excitement of life in Central Africa were clearly major influences upon his choice of career: arguably more so than his desire to cure bodies and save souls. During his period at Bandawe station between 1891 and 1893, he concentrated on hunting and fortifying the station against imaginary attacks regardless of repeated assurances that the station was not under threat. Furthermore, he scared his colleagues by carrying loaded firearms at all the time and reportedly even sleeping armed. "*Certainly Dr F. has misunderstood the mission call, or been led away by the knowledge of his brother's work at the North End*", wrote Elmslie, who was concerned about the sanity of his colleague and the safety of the mission.[113]

For missionary doctors, one particular sphere of potential heroism was medical activity – practice and research. Between the graduation of Livingstone in 1840 and the founding of Livingstonia in 1875, Western medical science, especially surgery and scientific laboratory medicine, seemed to be advancing at an unprecedented rate. Scottish hospitals and medical schools were significant centres of surgical progress. Chloroform was first used by Edinburgh surgeons and it became a standard anaesthetic in mid-nineteenth century Britain. Joseph Lister developed his antiseptic standard, based on the use of carbolic acid, in Glasgow during the 1860s. Developments in anaesthetics and antiseptics from the 1860s were as regarded revolutionary. Ulrich Tröhler has called the period between 1860 and 1914, "the heyday of modern surgery" and has pointed out that those antiseptic procedures reinforced prevailing notions of cleanliness in Victorian Protestant society.[114]

Towards the end of the nineteenth century, the heroic role of the missionary doctor was reinforced by the emergence of centres specialising in the new tropical medicine, such as the London and Liverpool Schools of Tropical Medicine. A prominent figure in British tropical medicine was Patrick Manson, another Aberdeen graduate who had for a time worked as a mission doctor in China. As tropical medicine emerged as a specialised discipline, doctors in the tropics could be viewed as heroes struggling to conquer strange and deadly diseases.[115] Mission-minded medical graduates with scientific aspirations could envisage themselves contributing to the progress of science by tackling new diseases in the tropics. This was true, for example, of Dr J.C. Ramsay, who had intensively studied bacteriology and who hoped to apply his

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112 van Ginneken 1999.
113 Elmslie to Laws 28 May and 27 June 1892, NLS, MS. 7896, 75, 91.
114 Porter 1997, pp. 304-333, 367-374, 428-445; Tröhler 1993, pp. 984-990.
115 Haynes 2001; Porter 1997, pp. 462-480; Worboys 1993, pp. 518-521.

skills to the study of malaria. After his appointment to Livingstonia in 1896, Ramsay approached the Foreign Missionary Committee of the Free Church for funds to buy a bacteriological "outfit":

> I have not the slightest hesitation in saying that I believe it would be one of the most beneficial scientific outfits that have ever gone up the Zambezi. To come to this conclusion we have to but look into the work that that branch of scientific medicine...has done to promote the science and usefulness of medicine.[116]

The limitations of actual practice could be turned into an advantage in the portrayal of images of medical and surgical heroism. Missionary publications could make the very "primitive" conditions the missionary doctors worked under appear particularly heroic, and it should be noted that for some recruits the decision to become a missionary clearly pre-dated any real interest in medicine.[117]

John McCracken and Peter Forster in their studies of Livingstonia missionaries emphasised the high proportion of missionaries who came from working-class, agricultural or artisan backgrounds with the notable middle-class exception of those from clerical homes. These observations also seem to hold true of many early medical recruits. Medical education in late Victorian Scotland was still comparatively cheap and available to a relatively large proportion of the population.[118] Robert Laws was a cabinetmaker's son, who left day school at the age of twelve to become an apprentice under his father. William Black was an orphan. Walter Elmslie and George Prentice came from small farms. Laws, George Steele, J.C. Ramsay and James Chisholm paid for their studies through their own work either partially or entirely.[119] They could all be called self-made men, who exemplified the Victorian Scottish ideas of self-help and the work ethic. To them, university degrees in medicine and theology were a means of substantial social and material advancement, which could also, in the Presbyterian tradition, signify that they belonged to the spiritual elite, as an outward sign of election.[120] They studied medicine at a time when the status and prestige of the medical profession was increasing considerably, and the profession became, in Porter's words, "a magnet for

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116 Ramsay to Smith 6 May 1896, NLS, MS. 7879, 99.

117 A.B. MacDonald, a Scottish missionary doctor in Nigeria who started his medical studies in 1913, recalled that as a youth when first considering foreign missionary service, he hesitated for a long time, unsure if this was a true "call" and whether he was worthy of it. After he had made the decision to become a foreign missionary, MacDonald who could never see himself as a minister, thought of a career as a missionary doctor, encouraged by literature offering "plenty of shining examples of men who had given valiant service as doctors, done marvellous operations in primitive conditions and brought untold relief to suffering humanity". MacDonald had never before been interested in medicine or knew anything about medical study or practice. MacDonald 1964, pp. 22-23.

118 Forster 1989, pp. 4-5; McCracken 1977, pp. 33, 181.

119 Barbour to Smith 7 November 1895, NLS, MS. 7873, 134. Chisholm to Smith 21 October 1898. NLS, MS. 7881, 79; Prentice to Smith 14 July 1892. NLS, MS. 7900, 63; Livingstone 1921, pp. 1-35; McIntosh 1993, pp. 1-15; For Steele, raised by his older siblings, see Thompson 1995, p. 65; For Elmslie, see *The Record,* May 1925.

120 Fields 1985, p. 109.

middle classes".[121] By contrast, the status of minister did not improve as the Victorian era progressed. Thus, more and more sons and daughters of the manse began to undertake medical studies in the late Victorian and early Edwardian period. According to the Livingstonia Staff-Book, at least six out of twenty doctors and nurses appointed to the mission between 1900 and 1914 came from clerical homes.[122] This corresponds with developments elsewhere: Walls has observed that of about eighty medical missionaries employed by the LMS between 1838 and 1914, the vast majority were recruited during the last thirty years of that period, and almost a quarter of these were the children of clerical missionaries.[123]

Agnes Robson was the daughter of George Robson (an influential Free Church figure, missionary statesman and Moderator) who studied medicine and graduated from the University of Glasgow with the intention of becoming a medical missionary. She was appointed to a post in India but after she met and married Donald Fraser, she joined Livingstonia.[124] When Dr Burnett, a son of the manse, was appointed in 1926, Donald Fraser believed that Burnett came from "the place where the best human material in the world is nurtured." By the late 1920s, the proportion of second- and third-generation missionaries among the new recruits of the United Free Church had grown so much that a writer in the *Record* wondered if the missionary calling was hereditary.[125]

What were the material gains or losses for the medical missionary in Central Africa? As a doctor, minister and second-in-command of the pioneer expedition, Robert Laws' starting salary of £300, was considerably higher than the average stipend of a United Presbyterian minister in 1875.[126] The standard salary at Livingstonia for a married medical or ordained missionary in the 1890s was £330 per annum (plus a passage out and back whilst on furlough), a sum which was comparable to starting salaries in the colonial medical service. In 1896, Dr Wordsworth Poole, a government medical officer in British Central Africa, was paid £350 and argued that he would only spend £150 each year in the Protectorate.[127] Married missionaries, of course, would have to provide for their families (Livingstonia doctors were paid an additional £10 per child per annum) but even so, the limited consumption possibilities in the field could allow savings to accrue. The profits from private practice could be more considerable, however. In British Central Africa, Poole claimed that a pioneer private practitioner in Blantyre could make as much as £500 or more a year.

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121 Porter 1997, pp. 348-352.

122 Livingstonia Staff-Book, NLS, Acc 7548 D 73. In addition, Nurse Ruth Livingstone-Wilson and her brother, Dr Hubert Wilson, were grandchildren of David Livingstone. In 1914, they started a medical practice in the same area, Chitambo, where their famous grandfather died. See *Livingstonia Mission Annual Report* for 1914.

123 Walls 1982, pp. 290-295.

124 *The Record*, March 1922, pp. 85-86. Mrs. Robson was a prominent figure in the Women's Foreign Mission Committee.

125 *The Record,* September 1926, p. 389; February 1929, pp. 57-58.

126 McIntosh 1993, p. 22. In contrast, Jane Waterston, appointed to "assist the medical men" and manage the boarding school for girls, was offered a salary of £150, to be raised to £200 over the five years. McIntosh 1993, p. 63.

127 Poole, quoted in Gelfand 1961, pp. 51-52.

When Dr George Robertson, a Blantyre missionary doctor, resigned and set up a private practice in town, Poole speculated that Robertson might have had this in his mind from the outset and that Robertson may have used the mission work to gain a foothold in the country, just as many missionaries who had become planters had done.[128]

Certainly, some mission doctors, particularly those who became heads of stations, also became materially wealthy during their careers and were powerful men by local standards. Alexander Caseby recalled that when an African patient was taken to Dr Laws' massive stone house (Zinyumba) at Livingstonia in the 1920s, he at first refused, claiming that a man who lived in such a mansion would certainly not bother to help someone as poor as himself.[129] Criticisms of their high standards of living were also levelled against missionaries by Europeans. In 1901, a young missionary doctor, Ernest Boxer, had to write a reply to the mission magazine after a Mr Grogan had blamed missionaries for *"living a life of idleness, ease and smug hypocrisy in a land that… offers more attractions than a Glasgow grocery establishment."*[130] The £330 per annum salary of old missionary doctors was not changed in 1920,[131] which meant the younger recruits had higher salaries following the revaluation of sterling.

In Central Africa, an ordained or medical missionary from a lower middle-class or working-class background, could end up living in a large manse with several house servants. The relative wealth of the missionaries in colonial society was apparent to both Africans and settlers alike.[132] Nevertheless, it seems probable that those doctors who appreciated the material or professional gains the most would at some point sever their connection with the mission because they could earn more in private or colonial practice.

While waiting for confirmation of his appointment to Livingstonia in 1900, Ernest Boxer argued that the "temptations" to choose a lucrative secular medical post at home were very strong, as he claimed there were many posts available, and the Committee kept him waiting for some time. When Robert Scott resigned from his post in Livingstonia in 1899 after his first year of service, he argued that there had not been enough satisfying medical work available.[133] However, for the mission doctors of the 1870s and 1880s (most of whom were graduates of Aberdeen or Glasgow Universities) employment prospects in

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128 Ibid. p. 32. Robertson had a home mission background: an Edinburgh graduate (LRCPSE), he had been working at the EMMS's Cowgate dispensary under Dr Lowe for two years, see Minutes of Foreign Missions Committee 3 March 1891. CSCNWW, *Nyasaland and Kikuyu, Vol. III*, 4.

129 Quoted in Mufuka 1977, p. 211.

130 *The Aurora* August 1901, p. 33. Grogan was presumably Captain Ewert Grogan, made famous by his Cape to Cairo journey in 1898-99 and later a leading settler and politician in Kenya known for his racist and reactionary views. I am grateful to Dr John McCracken for this reference.

131 Prentice to Ashcroft 9 October 1920. NLS, MS. 7885, 9.

132 Fields 1985, p. 109.

133 Boxer to Smith 27 June 1900, NLS, MS. 7883, 102; Scott to Smith 12 October 1899, NLS, MS. 7882, 88. Boxer, of course, may have overstated the alternatives available to him in order to push the Committee into appointing him more quickly.

highly competitive domestic medical market were uncertain. As Douglas Haynes has pointed out in his study of Patrick Manson, the late Victorian Scottish doctors, especially those who had not graduated from the Royal Colleges for Physicians and Surgeons, faced considerable difficulties in finding satisfactory posts in Britain. Of Manson's generation, ten out of a total of nineteen honours graduates in medicine at Aberdeen went into imperial service. During the period 1860–1900, at least eighteen per cent of Scottish medical graduates from Aberdeen took up overseas posts. The British Empire offered positions for medical men in the Army Medical Department, the Naval Medical Service, the Indian Medical Service and, in Manson's case, in the Imperial Chinese Maritime Customs Service.[134] Medical mission service was another major route into the empire for Scottish doctors, and in the case of Livingstonia, it was a comparatively well paid option.

Caroline Knowles has examined the case of Jane Waterston, the first Scottish woman to complete a full medical course, who worked in Livingstonia from 1879 to 1880. Knowles has convincingly demonstrated how mission connections within the British Empire enabled her to establish her identity as a professional doctor and disturb the gendered relationships of medicine in the process. Knowles' understanding of empire as a series of places and spaces, connected through travel routes, where identities and subjectivities (the ways of being in the world) are made and re-made, offers valuable insights for the study of missionaries (both male and female). Like Waterston, two laymen pioneer missionaries from the first Livingstonia party graduated in medicine following their return to Britain.[135] Unlike Waterston, they did not go back into the foreign mission field (although one of them worked for Glasgow Medical Mission, and was prevented by medical advice to return to the tropics). All medical posts in the homeland were open to men, and the empire provided medical graduates with a further variety of career opportunities.[136] It was easy to move from the mission field into a colonial career as an administration doctor, like David Kerr-Cross, or to a private practice among the settler community, as George Robertson did. However, it was significantly more difficult to move back into medical practice in Britain, especially after a long period in mission service and particularly from the late nineteenth century onwards when rapid changes in medical training rendered graduates who had spent years in Africa comparatively obsolete.[137] Some of those doctors who returned to Scotland

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134 Haynes 2001, pp. 14-20.

135 Knowles 2000, pp. 263-280; McCracken 2000, p. 64; MacDonald 2000, pp. 120-121.

136 Minutes of the Mission Council 12 October 1916. MNA 47/LIM/3/17. In 1888, ten out of sixty female medical practitioners on the English medical register worked in the foreign mission fields. *FCSMR* March 1889, pp. 80-81.

137 In 1925, after thirty years' of service, and partly deaf, Prentice pleaded for a return to a new tour of duty in Livingstonia for both ideological and financial reasons: "*To put in on a lowest platform I cannot see how at home I can make a living*". If he could not return to mission, Prentice wrote, he would try to return to Africa in some other service in order to earn his pension and support for his children. Prentice to Ashcroft 15 May 1925. Prentice to Ashcroft 15 May 1925. NLS, MS. 7888,56. Prentice was not re-employed in Livingstonia, but according to the mission Staff Record Book, he "went back to Africa". NLS, Acc. 7548 D 72.

retained a connection with their mission societies and acted as their medical consultants.[138] For Waterston, as will be seen, medical practice in Livingstonia turned out to be restricted sphere.

Arguably, for the medical missionaries (as well as for other missionaries), non-material rewards were of the utmost importance. Secular contemporaries, such as Dr Wordsworth Poole, sometimes viewed this in a rather negative light:

> There is a peculiar self-satisfaction about the missionaries. The idea of their self-devotion, their courage under difficulties, the hardships they undergo for the good of black mankind, is ever present with them. Each one takes a leaf out of Livingstone, Mackay, Harrington [sic] and pins it on to himself.[139]

Poole's description highlights another side of missionary self-sacrifice, a sense of the moral superiority of their work, their sacrifice for Africans, which for some extended to a sense of the superiority about the missionaries themselves.

A career in mission medicine enabled the creation of particular subjectivities in the colonial space, the creation of identities as missionary doctors and nurses, and mobility from one position to another. The benefits of the process could accrue in terms of social class or gender, materially and spiritually. In Knowles' study of the creation of masculinities, empire is traditionally seen as "forged in the scenes of conquest, massacres, repression and exploitation", but she has shown that women had less violent ways of making themselves and imperial spaces.[140] Medical missionaries made themselves in the spaces of healing, and although prospects of colonial adventure with elements of violence underpinned the expectations of many aspiring missionaries, their ultimate model for identification was Christ, as healer, saviour, muscular man and martyr. However, this model was also integral to the framework of unequal, complementary oppositions: saviour–saved, healer–patient, actor–subject, which were essential to British colonial thought, experiences and relationships with Africans.[141] It should be borne in mind that medical practice could be about power, domination and submission, and the violation of subject bodies as well as benevolent healing through consensus. In medical practice, meanings and interpretations for physicians, patients and others depended on the complex healer–patient relationships and individual experiences.

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138 For example, Dr Berkeley Robertson, who practised at Livingstonia in 1906-10, was in the mid-1920s the trusted doctor of the Foreign Mission Committee. AUL Special Collections, MS 3289, Caseby Papers, No. 19.

139 Gelfand 1961, p. 27. Poole refers, in all probability, to Bishop Hannington who was killed in Uganda.

140 Knowles 2000, p. 264.

141 Cannizzo 1996, p. 141, quoting Comaroff and Comaroff 1991, p. 88.

4 MEDICAL MISSION IN LIVINGSTONIA, 1875–1930

4.1 Pioneer period, 1875-1900

Staff and stations

Livingstonia had a strongly medical character from its inception in 1875. It was founded to continue the work of the most famous Scottish missionary doctor, Livingstone, largely through the efforts of James Stewart, a missionary who had qualified in medicine. From the outset, the mission always had one or more qualified doctors in the field. In comparison with other late Victorian British missions, Livingstonia had one of the highest ratios of qualified doctors to non-medical missionaries: sixteen out of the seventy European staff employed by Livingstonia in the period 1875–1900 were medically qualified.[1] Furthermore, from 1877 to 1927 the undisputed leader of the mission was its first medical officer, Rev. Dr Robert Laws. Doctors were prominent in the Mission Council, the highest local authority of the mission, established in 1886; until 1894, only ordained ministers and doctors were allowed a seat on the Council.[2]

The early policy of the mission was to have a "medical man" (Jane Waterston's short period at Livingstonia is discussed below) at the head station, first at Cape Maclear and then at Bandawe. Bandawe remained the mission headquarters and Laws' station from 1881 until the mid-1890s, when the Overtoun Institution was established on the Khondowe plateau. With the

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1 *Livingstonia: Central Africa.* Edinburgh, n.d. (January 1875). CSCNWW, Nyasaland and Kikuyu, Vol. I, 4, Rennick 2003, pp. 77-78. In contrast, there were only a handful of ordained, non-medical missionaries during this period.

2 McIntosh 1993, p. 93. Rev. Bain (d.1889) was the first non-medical ordained missionary at Livingstonia, and the only one within the first eighteen years of the mission. The mission was therefore largely in the hands of "medical men" until the 1890s: Laws, Stewart, Scott, Elmslie, David Kerr Cross, George Henry, and George Steele. It was only after the appointment of Reverends Donald Fraser and A.G. MacAlpine that influential non-medical leaders emerged at the mission. Lay missionaries gradually obtained limited representation, while no African was ever allowed a seat on the Mission Council.

appointment of doctors Walter Elmslie and David Kerr Cross in 1884 and 1885 respectively, Livingstonia expanded its medical network and new major stations were established in Northern Ngoniland and at the north end of the lake. Plans were drawn up for further expansion towards Central Ngoniland under the leadership of Rev. Dr George Henry (appointed in 1887). Of the stations established during the early expansion, Northern Ngoniland, where Elmslie was based, was the most successful.[3] Between 1894 and 1904 eight new doctors and six nurses joined the mission, many of whom were replacements for resigned, invalided or dead medical missionaries. Of the doctors from this period, George Prentice (appointed in 1894), Frank Innes (1899), James Chisholm (1900) and Agnes Fraser (arrived in 1901) remained in service until the 1920s.[4]

Pioneer medical policy

Despite the number of doctors amongst its staff, Livingstonia was not initially designed to be a medical mission. The primary objective of the medical officer was to keep the pioneer party alive, as "the fever" was recognised as a major obstacle to the founding of the mission station.[5] However, in his first medical report, written shortly after taking over the leadership of the mission in 1877, Laws clearly delineated the medical department as a separate sphere, alongside evangelisation, education, and industrial work, that would *"resolve[s] itself into the health of the mission staff, and the treatment of natives, who have come for relief."*[6]

Laws valued his medical degree and profession, but medicine was, like science, technology and crafts, "a handmaid of the Gospel": medicine had to serve the primary goal of evangelisation, through the demonstration of Christian goodwill, and European medical superiority, which should be used to

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3 *The Livingstonia Mission. Lake Nyasa and Uplands, East Central Africa. Five Years' Work – 1886-90.* Elmslie was relieved by Rev. Dr George Steele (1890-1895), and after his return the station was moved from Njuyu to Ekwendeni. Elmslie remained in uNgoni for most of his long missionary career, only transferring to Bandawe and the Institution to relieve Laws. Cross had difficulties establishing a permanent station in Karonga and after bitter conflicts with both fellow missionaries and the home authorities, he resigned in 1897. In Central Ngoniland, Henry's death in 1893 marked the end of the Livlezi station as part of Livingstonia, as it was handed to the Dutch Reformed Church. Elmslie 1901; McCracken 2000.

4 During the period 1875–1900, four missionary doctors (Black, Henry, Steele and Roby-Fletcher) died at Livingstonia. In addition, three doctors (Hannington, William Scott and Ramsay) were invalided home. After a period of work in Bandawe, Prentice was sent to a pioneer station in Kasungu, where he remained until his resignation in 1924. Chisholm enjoyed a long career as a medical missionary in Mwenzo, Northern Rhodesia. Innes worked first in Karonga and then at the David Gordon Memorial Hospital (DGMH) after its establishment in 1911. Agnes Fraser was not an appointed missionary but was a missionary's wife. She worked alongside her husband Donald in uNgoni, where they established a new station at Loudon (Embangweni) in 1904.

5 *Livingstonia: Central Africa.* Edinburgh, n.d. (January 1875). CSCNWW, Nyasaland and Kikuyu, Vol.I, 4.

6 Medical Report for 1876–1877, Cape Maclear Journal 1875-1876, NLS, MS. 7908.

attack indigenous medico-religious beliefs and practices. In 1890, Laws described missionary medicine at Livingstonia as *"one of the most efficient means of breaking the bonds of superstition, and enabling the people to understand the practical teaching of the Gospel"*. In the pioneer phase, medicine was often used as a tool of mission diplomacy to secure the goodwill of the rulers of the region and to appeal to people to come to the mission. During this period missionary doctors had to be ready to sacrifice their medical ambitions in order to concentrate on other spheres of work. Furthermore, in Laws' opinion, they had to be prepared to refuse to perform difficult surgical operations if their subsequent failure could damage the mission's reputation, as he advised to young medical students in 1900. To protect the interests of the mission, missionary doctors had to be ready to accommodate the Hippocratic oath with their duty as missionaries.[7]

During the pioneer period and in new stations, doctors were preoccupied with general missionary and building work as well as establishing a medical practice. Even after the stations were well established, the Livingstonia policy of preference for ordained medical missionaries meant that doctors would work extensively in evangelistic and educational departments, frequently working as teachers and often as heads of stations. Laws, Elmslie, Prentice and Chisholm all became long-standing leaders of their respective stations. As Rennick noted, the combination of medical and clerical roles could reinforce an individual missionary's authority, but it could also lead to conflicts between professionally ambitious doctors and the mission authorities;[8] conflicts which became increasingly apparent from the 1890s onwards.

Early practice

In his first medical report, Laws summarised his medical work among the Africans at Cape Maclear between 1876 and 1877 thus:

> … medical work is still in its infancy. I can present no glowing report of a series of brilliant operations, and crowds of people daily receiving medicine. As yet, ours is more sombre work, such as prescribing Epsom salts, rhubarb pills, and extracting teeth. Yet even in this the confidence of the natives has greatly increased…[9]

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7 *The Livingstonia Mission. Lake Nyasa and Uplands, East Central Africa. Five Years' Work – 1886-90;* Rennick 2003, pp. 106-108, 133. In his reminiscences, Laws claims that Stewart originally planned Livingstonia on a "four-fold basis – evangelistic, medical, industrial, and educational". Laws 1934, p. 6. However, from the evidence it appears that this was the formal order established by Laws himself in around 1877. Earlier schemes do not mention a distinct medical department. The pioneer policy and perception of medicine as a "handmaiden" was best reflected in the work of Laws and Elmslie. In contrast, Cross emphasised medical work more strongly than his colleagues, even as a goal in itself.

8 Rennick 2003, pp. 115, 132-140.

9 Medical Report for 1876-1877, Cape Maclear Journal 1875-1876, NLS, MS. 7908.

In 1880, the most common diagnoses recorded in Laws' patient book were "fever" and "diarrhoea", followed by "ophthalmia".[10] The "increasing confidence" of African patients was a recurrent theme in missionary doctors' reports.

Epsom salts and rhubarb pills were among the relatively cheap medicines commonly administered to Africans. The supply of medicines at Cape Maclear and Bandawe remained very limited, and the more effective drugs were rare or expensive. Drug prices were inflated by the cost of transportation to Central Africa. In early 1884 William Scott, then in charge of Bandawe, requested additional medicines in a letter to Laws who was at that time in Scotland.[11] In February 1885, Scott ordered supplies of ergot (for midwifery cases), eserine, sulphate of atropia, red iodide of mercury, opium pills, sulphur ointment, belladonna liniment and sulphate of zinc. Medicines were subject to breakages and loss in transit, but Scott was happy to report that of the last medicine order, only one bottle had been broken. In October 1885, Scott and Elmslie were in need of more sulphur, liquid potash, "solution or the discs for testing urine", castor oil, opiates, hydrobromine acid, phosphoric acid, arsenicals, liquid strychnine, and nitrate of potash. Most of these medicines had been completely exhausted in the dispensary.[12] Opiates, such as laudanum and morphia, were used to treat dysentery and diarrhoea, and for general pain relief, while by 1895 cocaine was being used as a local anaesthetic.[13]

Early surgical practice was limited by, among other things, a lack of instruments. When he first left Britain, Laws carried just a surgical "emergency case".[14] The standard instruments used by the pioneer missionaries included surgical knives, bone saws, large and small forceps for obstetrics and dentistry. Chloroform was used as anaesthetic from the start, but it is unclear if emergency operations were sometimes performed without it.[15] During the first operations, chloroform was administered by covering the patients' nose and mouth with a soaked cloth, although later an anaesthetic machine with a mask was used.[16]

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10 Daily Journal of Livingstonia Mission, entries for 1880. MNA 47/LIM/10/2. In at least one case, Laws regarded ulcers as "syphilitic". Daily Journal of Livingstonia Mission, entries for p. 41. MNA 47/LIM/10/2.

11 Scott to Laws 7 March 1884. NLS, Acc. 9220, (1) (ii). Scott noted that sulphur ointment in particular had been popular among Africans to alleviate itching. "Epsom salts" were hydrated magnesium sulphate, and were used as a purgative and as a bath or soak to alleviate inflammation or swelling, and were still commonly used in the 1920s. Haubrich 2003, p. 79.

12 Scott to Laws 17 February and 13 October 1885. NLS, Acc. 9220 (1) (iii).

13 *Half-yearly report of Livingstonia Mission, Jan.-June 1895,* p. 9. For opiates, see Thompson (ed.) 1989, p. 27; Fabian 2000, pp. 66-68.

14 Laws to Main 3 January 1879. NLS, MS. 7876, 240.

15 In July 1884, William Scott reported that owing to a lack of truss, he had been unable to help a patient suffering from a hernia. Scott to Laws 17 July 1884. NLS, Acc. 9220, (1) (ii). At the Blantyre Mission station in Mlanje in 1894, an emergency amputation of an arm was performed with a pocket knife and a joiner's keyhole saw. Chloroform was not mentioned. *Life and Work in British Central Africa,* August 1894.

16 In 1882, surgical cases included *"revulsion of nail 2, abscess 1, broken finger 1, Bilat: dislocation of jaw reduced 1; Ganglion on back of hand evacuated 1, Tumour of nose extracted 1, amputation of right hand 1...broken heads, burns &c."* Daily Journal of Livingstonia

A minor form of surgery performed by Livingstonia doctors from the outset was the extraction of teeth. In the 1870s and 1880s Laws, Elmslie and William Scott pulled teeth in Cape Maclear, Njuyu and Bandawe with some appreciation from their African patients. Between 1884 and 1890, Bandawe doctors extracted a total of 353 teeth. Basic dentistry remained part of the repertoire of medical missionaries throughout the period studied. Unlike most operations, it could be performed while on itinerant tours in the villages. Dental practice was not restricted to qualified medicals: Donald Fraser, for example, had a successful dental practice in uNgoni. Tooth forceps remained important instruments for travelling missionary doctors into the 1900s.[17]

The doctors classified their cases as either "medical" or "surgical". Dr Henry's case analysis of the cases treated during 1889 in the Livlezi Valley reveals that most medical cases were treated for "fever" (15.1 % of all cases treated for the first time, and over one third of the total number of medical cases) and diarrhoea (14.2%) followed by "Catarrh and Bronchitis" (9.9%). Of the surgical cases, the most common were treated for "ulcers and abscesses" (17.1%), "skin diseases" (8.9%), and "eye cases" (5.1%).[18] Surgical cases were slightly more common than medical cases in the dispensary records, probably because they were more likely to require prolonged treatment. In Henry's practice in 1889, surgical cases accounted for over sixty-two per cent of the cases, while in the Bandawe dispensary attendances for the 1880s surgical cases comprised about fifty-six per cent of total attendances.[19]

Early missionary medicine for Africans was almost entirely curative or palliative. However, vaccination against smallpox was one significant form of preventive medicine that the pioneer missionaries could provide. Laws had a supply of lymph with him in 1875 (which had been provided by Dr Russell, the medical officer of Glasgow) which he intended to use to vaccinate African children.[20] It is unclear exactly when Laws successfully vaccinated a patient, but by 1883 the schoolboys at Bandawe had been vaccinated. Laws administered

Mission, "Surgical Notes" for 1882. MNA 47/LIM/10/2; Good 2004, p. 402. The remains of one "Anaesthetic machine" are on display in Stone House Museum, Livingstonia.

17 Daily journal of the Livingstonia Mission. MNA 47/LIM/10/2; Steele, quoted in *FCSMR* December 1894, p. 285; *Annual Report for 1902,* p. 37; Prentice 25 May 1905, quoted in *Reports on Foreign Missions* 1904 or *Proceedings and Debates 1905,* pp. 73-74.

18 See Appendix 4.

19 Ibid.; Daily journal of the Livingstonia Mission, entries for April 1880. MNA 47/LIM/10/2. Tropical and other ulcers made up a considerable proportion of African ailments treated by missionaries in Malawi. Many ulcers develop following other infections such as yaws, smallpox or jiggers, and, if untreated, can lead to bone degeneration, gangrene and amputation. Good 2004, p. 283. In 1895, Prentice claimed that at the Bandawe dispensary, *"Of a dozen surgical cases of a morning 11 are likely to be ulcers, and of these 10 will probably have a history of 'Matakenya' (jigger)," Half-yearly report of Livingstonia Mission, Jan.-June 1895,* p. 8.

20 Laws to Russell 19 May 1875. Wellcome Institute Library, MS. 5143/30/1. On Russell, see Robertson 1998. Rev. Waller had vaccinated Africans in the Shire Highlands during the ill-fated UMCA mission, and informed Laws that he had had at first difficulty in *"getting it to take on the blacks"* but the difficulty had been overcome by *"first putting a little blister on the place, & then vaccinating afterwards."*

304 vaccinations in 1888, of which five inoculations failed because of "bad lymph".[21]

Dispensaries

By 1877, Laws and Black were already acknowledging that their medical practice was severely hampered by a lack of hospital buildings and accommodation for resident patients. At Cape Maclear it is unclear if there was a dispensary room or even a space specifically designated for this purpose. The pioneer missionaries were busy during their first years at the Cape: they built their own living quarters, the school, boarding houses, various outbuildings and roads; cleared trees; planted and cultivated the fields and gardens; and made furniture, among other tasks.[22]

After the move to Bandawe in 1881, Laws built an "infirmary" which was reported to have collapsed some months after his departure in 1883, and which had not been rebuilt by 1886. By the late 1890s, however, the mission had established dispensaries at all its major stations. Dispensaries were often separate rooms in the doctor's house, where medicine bottles and other supplies were kept. Throughout the period 1875–1900, patient accommodation was located in temporary and makeshift buildings. In-patients were housed in cookhouses, stables and cottages. Medical practice in Livingstonia was concentrated in the dispensaries, and accounts of in-patients are only sporadic.[23] In Karonga, where Cross had constructed the first purpose-built Livingstonia mission hospital, during 1894 there had been an average of three resident cases at one time, but this was an exceptional year. Because of the limited patient accommodation, lack of nursing staff and other resources, major surgery and other therapies that required prolonged treatment, supervision and care of the patient were rare. Medical practice was largely limited to dispensing drugs to out-patients. Some serious cases were treated in their homes, and in late 1894, Prentice reported visiting one patient with a gunshot wound eighteen times.[24]

At Bandawe station in 1894, for example, there was no accommodation for in-patients. The medicines were kept in a room in the old manse. Prentice recalled later that there was no table in the dispensary upon which the patient could be placed for an "overhaul". Furthermore, his ambitions for a hospital met with suspicion from older missionaries: "*Speak of a hospital, and you were told that no native would sleep in a room where another had died, and that the first death in*

21 Laws' diary entry for 5 July 1883. EUL, Gen. 561/3; Bandawe Station Journal entry for 21 May 1883. NLS, MS. 7911; Daily journal of the Livingstonia Mission. MNA 47/LIM/10/2. In 1885, there were two recorded vaccinations.

22 Medical Report for 1876-1877, Cape Maclear Journal 1875-1876, NLS, MS. 7908; Black to Smith 3 March 1877. NLS, MS. 7876, 176.

23 Bandawe Station Journal entry for 25 February 1886. NLS, MS. 7911; Rennick 2003, pp. 81-83, 97.

24 Cross to Smith 8 January 1895. NLS, MS. 7878,24; *Livingstonia Mission Report for 1894*, p. 7.

hospital would close its doors."[25] Prentice, an ambitious surgeon, openly admitted that he considered most of his cases to be "trivial". In 1896, he observed that he would sometimes prescribe and dispense the necessary pills for forty or fifty patients within two hours. During his term at Bandawe between 1894 and 1899 Prentice did, however, develop the temporary medical buildings. He oversaw the construction of a cottage-dispensary with a waiting room and a consulting room, and a wattle and daub hospital originally designed as a maternity hospital, but eventually used as a general all-purpose "hospital".[26]

Outpatient attendances

In his 1880 report, Laws recorded the first attendance figures of patients treated in the Cape. During the previous nine months there had been 776 attendances, of which 495 patients were seen for the first time.[27] Thus, 495 people had visited the dispensary during these nine months, and the rest of the visits were second or subsequent visits by a pre-existing patient. It is often difficult to gauge from mission reports how many of the attendances were "new" and how many "old" cases, and how many people actually visited the mission doctor. On average, Laws treated fifty-five new patients per month: less than two per day.

In 1882, Laws recorded that 3,104 African cases had been treated, of which 800 were seen on journeys. At Bandawe, 2,304 cases were treated, of which 1,843 were seen for the first time. January (490 new patients) and February (453 new patients) were particularly busy months: over half of all the new patients at Bandawe were treated during this time. During these exceptionally heavy months, Laws treated more than fifteen patients a day on average. In the early 1880s, a typical outpatient was treated only once. Generally medicine would be dispensed, lotions applied or ulcers would be cleaned and dressed during a single visit, although on occasion there would be a number of subsequent visits or a prolonged stay in the mission. In April 1880, for example, Laws treated one woman six times for ophthalmia and another for four days for "bronchitis & pleurisy".[28]

A prominent group of patients of the Bandawe dispensary were children. Of recorded attendances between 1884 and 1890, 38.9 per cent were children, while women made up the smallest group of patients (28.3%). Both women and children were largely "surgical cases" (the most common ailments being ulcers, abscesses and ophthalmia) that were treated using dressings, lotions, and minor surgery. In turn, men (32.8 % of attendances) largely received their treatment in the form of medicines.[29]

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25 *Report on Foreign Missions for 1899*, pp. 98-99.

26 Ibid.; *Report on Foreign Missions for 1896*, p. 101; Prentice to Smith 24 June 1895. NLS, MS. 7878, 200.

27 Livingstonia Mission Report for 1880, p. 3. NLS, MS. 7904.

28 "Summary of Native Patients, 1882", entries for April 1880, Daily journal of the Livingstonia Mission, MNA 47/LIM/10/2; *Report on Foreign Missions for 1882*, pp. 64-64.

29 Appendix 2.

TABLE 1 Cases treated at the Bandawe dispensary, 1882–1890[30]

Year	1882	1883	1884	1885	1886	1887	1888	1889	1890
Attendances	2,304	c. 7,000	10,019	6,348	5,801	3,905	5,157	4,484	4,484
Patients	1,843	n/a	5,638	2,944	1,994	1,999	2,065	2,688	2,557
Ratio	1:1.25	n/a	1:1.78	1:2.16	1:2.91	1:1.95	1:2.5	1:1.67	1:1.75

Medical practice at Livingstonia expanded after the move to Bandawe, a more populous area than Cape Maclear. During 1883, 7,000 cases were recorded and over 10,000 in 1884. These numbers were represented in the mission rhetoric, propaganda and appeals as statistical proof of an increasing African confidence in the Livingstonia doctors, a triumph of the medical mission.[31] Such writings gave an erroneous impression of the actual number of people benefiting annually from the missionary medicine in Livingstonia. The record level of attendances during 1884, when 5,638 people visited the dispensary was an exception. On average, during the 1880s, slightly over two thousand people consulted the missionary doctor at Bandawe each year. The published statistics of medical mission work need to be taken "cum grains". Conversely, it is also possible that some patient figures are too low due to omissions and errors.

Laws recorded 13,314 attendances at the Livingstonia dispensary in Khondowe in 1898–99, and 4,031 individuals were treated during that year.[32] The ratio of patients to attendances was 1:3.3, clearly more than in Bandawe during the 1880s. There may have been some justification for the claim that African patients' confidence in missionary medicine was slowly increasing, as repeat visits to the dispensary indicated a basic trust as well as continuing illness. However, in all probability the increased treatment of ulcers, which required repeated dressing and which became more common as the missionaries employed African assistants and "dispensary boys", was a significant factor which contributed to the rise of attendances in the 1890s and early 1900s.

Charles Good has, in his study of missionary medicine at the UMCA stations in the Lake Malawi region, approximated the ratio of patients to outpatient attendances, based on records during the period 1945–66, to have been about 1:10.[33] However, this was during the modern period, when annual outpatient attendances were recorded in hundreds of thousands, when missionary medicine was an established alternative in areas near hospitals and dispensaries, and when mobility and transport conditions had changed considerably from the early colonial period. It is unlikely that in the period

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30 Daily journal of the Livingstonia Mission. MNA 47/LIM/10/2.

31 In 1927, in a tribute to the retiring Robert Laws published in the *Scots Observer*, Donald Fraser claimed that it was now possible to *"count the 70,000 patients in a land which Dr Laws found with no better healing than the magical 'medicine man' could give." Livingstonia Mission of the Free Church of Scotland at Lake Nyasa: Eleven Years' history and appeal*. Glasgow 1886, p. 13; Fraser 1994, p. 58.

32 *The Livingstonia Mission Report for 1898-99*, p. 8; Cf. Rennick 2003, p. 97.

33 Good 2004, pp. 330-331.

under review in Livingstonia, an average outpatient would visit the dispensary ten times a year, but from the evidence it seems that at the turn of the century in Livingstonia, the ratio of patients to attendances had slowly decreased, with more patients making frequent visits to the dispensary.

Lay missionaries and medicine

The pioneer lay and clerical missionaries helped in medical work, first aid and sometimes worked as lay doctors. The most prominent layman in this respect was the engineer Allan Simpson from the first Livingstonia party, who practised medicine at the Bandawe observatory station between 1878 and 1879. Simpson prescribed medicines and treated cases of fever, ulcers, dysentery, syphilis, snake bites, and blood poisoning, among other complaints, and performed minor surgery when possible. Lacking the necessary forceps and "a suitable knife" he refused to operate on a man with a bullet in his back. Simpson, who was mentioned in the Livingstonia Staff-Book as an "amateur physician",[34] clearly had medical ambitions. Under pioneer conditions, lone Europeans had to treat themselves and their dependants. Furthermore, pioneer practice, which consisted of the prescription of simple drugs, dentistry and minor surgery, did not require great specialisation and knowledge, making lay European practice possible and necessary at a time when it would have been condemned as quackery in Britain.[35]

By the 1890s, layman practice within the Protectorate was in retreat. The experiences of James Henderson (a missionary educationalist and the first Headmaster of the Overtoun Institution) illustrate this development. During his studies in Edinburgh, Henderson had also taken a considerable portion of a medical course before his appointment to Livingstonia in 1895. In cases of emergency in Livingstonia, Henderson had practised some minor medicine. However, when both Dr Laws and Mrs Thompson were taken seriously ill in 1896, he felt troubled about treating his colleagues. After being relieved by Elmslie, Henderson complained that his patients had not trusted him even though his treatment had been virtually identical to that of Elmslie. The main problem for Henderson was not his lack of skills, but that his white patients, one of whom was a doctor, would not place their trust in his treatment. The treatment by Henderson and Elmslie was essentially the same, but because the patients' improvement began only after Elmslie took charge it created the impression of a crucial difference between the amateur and the professional.[36]

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[34] Simpson to Laws 22 June 1879. NLS, Acc. 9220, (1), (i); Bandawe Journal entries for 28 July, 7 and 8 August 1879, and 3 March 1880. NLS, MS, 7910; Livingstonia Staff-Book. NLS Acc 7548 D 72.

[35] After leaving the mission, Simpson joined the ALC and later became a planter in the Protectorate. He wrote enthusiastically on health issues in the *Life and Work in British Central Africa* in 1894, providing idiosyncratic "Health Notes" for European newcomers with the authority of a rare individual who had survived nineteen years in the tropics. *Life and Work in British Central Africa,* August-September 1894.

[36] Ballantyne and Shepherd 1968, pp. VII, 204.

Medical practice in Livingstonia was eventually concentrated in the hands of the professionals in hospitals and dispensaries. After the turn of the century, apart from the appointed doctors and nurses, it was largely medically qualified missionary wives such as Agnes Fraser and Margaret Stuart, who practised medicine at their stations when necessary. Conversely, the husbands of these medically qualified women continued to assist their wives in medical emergencies. Livingstonia was exceptional, as Rennick has pointed out, in its policy of allowing nurses to practise medicine after marriage.[37]

The case of Jane Waterston

Although co-operation and consultation between European doctors in Central Africa could be close and collegial, conflicts and contests between medical professionals within the mission could have severe and lasting repercussions for mission policies. In the case of Livingstonia, an example of this occurred with the arrival of the first woman doctor, Jane Waterston.[38]

Waterston, who was in regular correspondence with Dr Stewart, had been a mission teacher in Lovedale prior to studying medicine in London and Dublin. She arrived at Livingstonia in November 1879. Laws did not cope well with the arrival of this older, experienced and unmarried female missionary, who above all was also a medically qualified professional.[39] The conflict between Laws and Waterston over medical authority began almost immediately upon her arrival. Waterston described their discussion in a letter to Stewart:

> … Dr Laws began to describe the sort of person he dreaded to see come to the country. I listened quietly and then said, 'Dr Laws, do you know that you have just been describing me?' He answered, 'but you have this comfort, that women stand malaria better than men', I said, 'I know that' and then proceeded to give him Surgeon Major Gunn's verdict, a man of…larger experience which, of course, was a direct contradiction of the Doctor's…neither malaria nor anything else will be able to prevent me, as for trying to frighten me, I am not a bairn nor a fool and my professional knowledge stands me in good stead.[40]

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37 Rennick 2003, p. 178. Arguably, there were both economic and health reasons for this. A missionary's wife was an unpaid agent and if she could ease the medical work of the burdened mission, especially after 1908, such assets were to be used. Furthermore, as discussed below, in the large Livingstonia sphere it was recognised that the medical skills of wives were important for the health of the staff, and that marriage in itself was good for missionary health.

38 Another example would be the bitter, long-standing feud between doctors Cross and Elmslie in which accusations of plagiarism, abandonment and even insanity were made, and which ended in Cross' resignation in 1895.

39 See Bean and van Heyningen 1983; Knowles 2000; MacDonald 2000, pp. 120-133; McIntosh 1993, pp.62-63. McIntosh suspects that if Laws, who had a low opinion of Waterston's work in general, had given her more professional respect, she might well have remained with the mission.

40 Waterston to Stewart 10 November 1879, LJEW, p. 161.

Waterston felt that Laws was trying to frighten her and that from the outset he showed a lack of professional respect towards her. In retaliation, Waterston challenged the younger Laws by quoting an older medical authority from the homeland. The idea that women were more resistant to malaria than men was one of the older theories in Victorian medicine. In humoral pathology, fevers had been attributed to excess, and had often been treated by blood-letting. Menstruation was accordingly regarded as a natural means of balancing the body. In Southern Africa, David Livingstone and John Mackenzie had associated the supposed low mortality among African women from malarial fevers with menstruation, which was seen as a way of expelling the poison from their systems. Menstruation was a key marker of physiological difference in general medical discourse about the sexes: it could not only explain perceived resistance to fever, but it could also signify physical and mental inferiority. Victorian conservative authorities consistently argued that women were physiologically unsuitable for medical education. Menstruation was treated as a disease, and physicians commonly prescribed complete rest during periods.[41] In this context, Laws' comment about women and malaria can be regarded as especially provocative.

Waterston was not on equal footing with male medical graduates in any professional struggle at the time. Being one of the very first female medical graduates in Britain, she had obtained her training through an unorthodox route. In the public mind, women were not easily accepted or recognised as doctors. While Laws was always "Doctor", Waterston, who had a licentiate degree from Dublin, was referred to as "Miss Waterston" in all mission correspondence. Her sphere of work was described as, "the female, and female medical departments".[42] The emphasis on "female medical department" may have been intended to placate those readers who would have found the idea of a woman treating men, and particularly African men, disturbing. There is no further evidence that Waterston's and Laws' African practice would at any point actually have been divided by the sex of their patients, and in February 1880 Waterston wrote that she had actually taken over much of the increasing African medical practice at the station. However, her treatment of Europeans was clearly limited. When James Stewart (a civil engineer and a cousin of Dr Stewart) fell ill, Waterston made a request to see him. Laws informed her that Stewart was too "sensitive", to be seen by Waterston. She did not see Stewart at all during his illness.[43]

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41 Comaroff and Comaroff 1997, p. 355; Gay 1993, p. 363. For example, in the United States in the 1870s and 1880s, an influential group of physicians had based their opposition to higher education for women on the biological arguments as presented in Dr H.E. Clarke's book, *Sex in Education* (1873). See Morantz-Sanchez 2001, p. 155. For the perceived differences in male and female nerves, see Oppenheim 1991, p. 152 and *passim*. Some nineteenth-century scientists explained perceived gender inequalities with differences in size or mass of brain or skull, analogously with racial theory. Stepan 1999.

42 See, for example, *Reports on Foreign Missions for 1879*, pp. 33-35.

43 Waterston to Stewart 14 February 1880. LJEW, pp. 166-168.

By mid-December 1879, after only a month at Cape Maclear, Waterston had already written to Stewart asking him to arrange her recall. Waterston ultimately resigned after just six months at Livingstonia. The main reasons for her resignation were her feeling that she was not respected professionally, disappointment with the mission policy towards Africans, disillusionment with the reality of the mission and personal conflicts, particularly with Laws.[44] She was particularly bitter that, despite her experience and qualifications, she was given the most basic teaching work in addition to medical work. *"I was judged fit to teach Anatomy in London. I am thought fit to teach Alphabet here"*, she complained to Stewart.[45]

In her letter of resignation to Laws, Waterston compellingly stressed, as one doctor to doctor, her need to maintain her professional occupation which she argued would be impossible if she also had to continue teaching:

> 1st. Because it [her medical profession] has cost me everything to get it. 2nd. It is all I have to fall back on if invalided home and therefore I cannot afford to grow rusty in it. 3rd. That, while I dislike merely elementary teaching, my whole heart is in my medical work.[46]

Although there were several African patients suffering from fever and bronchitis at the station, Waterston claimed in her letter of resignation that there was only sufficient work for one doctor at Cape Maclear. This was an acceptable excuse for the home mission authorities who did not request any further details. In its discussion of her resignation medical arguments were raised in the Mission Council. Stewart, sympathetic as he was to Waterston, stated that the "climate" in Livingstonia was not "suitable" for her "temperament and constitution". Although Waterston prided herself on her strength and health, she connected the strain that she had been feeling to illness, which she feared would recur.[47] It would be fourteen years before the next single female missionary was appointed to Livingstonia. As late as 1914, the mission authorities at home generally held that Livingstonia was an unsuitable field for unmarried "lady medicals", although the Mission Council in the field was willing to accept female doctors. In the 1920s, although the Foreign Missions Committee was favourable towards women recruits, new objections were raised by both men and women in the field. It was claimed that some nurses would feel unable to work under women doctors and that African patients would have difficulty discussing their internal complaints with an

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44 Waterston to Stewart 11 December 1879. LJEW, p.162.

45 Waterston to Stewart 14 February 1880. LJEW, pp. 151-152, 168.

46 Waterston to Laws 19 February 1880. LJEW, p. 171. Eventually, Waterston returned to Cape Colony, started a successful private practice and also worked with the Lovedale Institution. She obtained her M.D. from Brussels with high distinction, and became a well-known and popular medical figure in South Africa.

47 Waterston to Stewart 14 and 19 February 1880; Stewart to Young 20 April 1880.LJEW, pp. 168-173. "Temperamental suitability" was a primary concern for the nineteenth- and early twentieth-century recruiters of woman missionaries. See Kirkwood 1993, p. 34

unmarried woman. Certainly, some European women refused to be treated by a woman in the 1920s.[48]

4.2 Emergence of hospital medicine

Expansion in the early 1900s

From about 1900 to 1924, four of the main Livingstonia stations were headed by doctor-clergymen: Laws at the Institution, Elmslie at Ekwendeni, Prentice at Kasungu, and Chisholm at Mwenzo. In contrast, Rev. A.G. MacAlpine was largely in charge of the station at Bandawe and Rev. Donald Fraser at Loudon. The new stations of Tamanda and Chinsali were without a doctor.[49] At Bandawe, the doctor was second in command to MacAlpine, in Chitambo Rev. Malcolm Moffat was in charge, while in Loudon medical practice was the domain of Agnes Fraser. All of these doctors continued in mission service into the 1920s. By 1906, the Livingstonia sphere of operations had expanded to the extent that Laws estimated it to be the size of England and part of Wales. By the First World War, five new stations had been founded in the Nyasaland Protectorate and Northern Rhodesia. In Rhodesia, the BSAC had made a request for more medical missionaries since the establishment of the Mwenzo station at the turn of the century.[50]

Laws and Elmslie held that medical missionaries were particularly valuable during the establishment of new stations, such as Chitambo in Northern Rhodesia. However, while the missionaries were planning large-scale expansion westwards, the resources for such an expansion were becoming increasingly scarce. The death of the principal supporter of the Livingstonia Mission, Lord Overtoun, in 1908 was a severe financial blow. Furthermore, there was a lack of both lay and medical recruits.[51] No new doctors and just one nurse were recruited between 1907 and 1913. Resources were just beginning to improve in 1914, when the First World War disrupted the expansion plans.[52]

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48 Minutes of the Mission Council 20 May 1914. MNA 47/LIM/3/17; Mamie Martin 5 August and 18 December 1923; Jack Martin 26 November 1923. Sinclair 2002, pp. 149, 166, 171.

49 *Annual Reports* for 1900-1914; *Reports on Foreign Missions* 1918-1929. The European staff at Karonga station changed frequently.

50 Laws 20 June 1906. NLS, Acc. 7548 D 71, Letters to the Sub-Committee 1906, p. 101; *Annual Report for 1914;* Laws 9 August 1905. NLS, Acc. 7548 D 71, Letters to the Sub-Committee, 1905, p. 79.

51 Elmslie 4 December 1905; Laws 22 December 1905. NLS, Acc. 7548 D 71, Letters to the Sub-Committee 1906, pp. 26-27, 34-36; Thompson 1995, p. 138.

52 *The Record* May 1929, p. 219; *Annual Report for 1913*, pp. 48-49; Thompson 1995, p. 174; *Report on Foreign Missions 1923.* Chitambo station had exceptional symbolic significance for Livingstonia, being located close to Livingstone's place of death. Dr Hubert Wilson, Livingstone's grandson worked for most of his career as a medical missionary (between 1914 and 1929) in Chitambo.

The First World War heavily disrupted the work of Livingstonia, especially in the northern stations of Mwenzo and Karonga. The medical course at the Institution hospital was cancelled. In addition to the redeployment of staff into military service, there also was a shortage of drugs, surgical dressings and other medical supplies.[53] In late 1919, the only Livingstonia doctors in the country were Laws and Innes at the David Gordon Memorial Hospital (DGMH) at the Institution and Agnes Fraser in Loudon. After the war, Hubert Wilson took over leadership of the DGMH and the medical course from 1920 to 1922, followed by John Todd, a non-ordained, full-time doctor (1923–26, 1928–32). However, Laws continued to assist his colleagues and practise medicine in the younger doctors' absence despite his age almost up until his retirement at seventy-seven.[54] The 1920s saw the resignation and retirement of prominent pre-war missionaries, Innes (1921) Elmslie (1924), Prentice (1925), Frasers (1925) and finally Laws himself in 1927.[55]

Nurses

The role of nurses at Livingstonia had increased markedly by the First World War. Until the turn of the century, medicine at Livingstonia had been predominantly practised by male doctors. In comparison, in 1920, the mission employed six European nurses and six paid doctors, excluding Agnes Fraser.[56] The employment of missionary nurses from 1898 onwards, and the establishment of more permanent hospitals were preconditions of more extensive surgery, regular in-patient treatment and the training of African medical assistants and nurses.

The nurses often taught in addition to nursing. This fusion of roles was apparent in the careers of the first nurses appointed at Livingstonia, Maria Jackson and Margaret McCallum. They first worked at the Overtoun Institution in 1898, while the "hospital" was temporary, and where they also taught women and girls. McCallum was a vocal advocate of missionary medicine and emphasised the necessity of employing more qualified nurses. Eventually, Jackson and McCallum married Livingstonia missionaries Malcolm Moffat and

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53 Livingstonia Staff Record Book. NLS, Acc. 7548 D 72; Thompson 1995, pp. 174-175; Laws to Ashcroft 18 April 1919. MNA 47/LIM/1/1/18. Laws sent medical supplies to the colonial medical officers, and patients were sent to DGMH, which at one point was treating several convalescent soldiers. After the war, "huge numbers of surplus instruments flooded the British market", and many hospitals could choose what they wanted for the first time. Lawrence G. 1992, p. 305. That this was not the case in Livingstonia reveals both the financial crisis of the mission and the significantly higher prices of instruments in Africa.

54 Ashcroft 30 July 1920. NLS, MS. 7885, 6; Elmslie to Ashcroft 18 April 1922. NLS, MS, 7885, 108; Livingstonia Staff Record Book. NLS, Acc. 7548 D 72. Laws to Wilson 16 February 1927; Laws to Chesterman 21 April 1927. MNA 47/LIM/1/1/25 (a), 816.

55 Livingstonia Staff Record Book. NLS, Acc. 7548 D 72; Thompson 1995, p. 226.

56 *Report on Foreign Missions for 1920*.

Charles Stuart respectively.[57] After they married both (but most notably Margaret Stuart) continued with their medical practice.

The three nurses appointed in 1900-01 all came from clerical homes and two of them joined the mission as honorary workers supported by outside donors. In contrast, the four nurses appointed between 1904 and 1914 were all certified nurses with hospital experience and were employed on full mission salaries.[58] The need for a fully qualified nurse at the Institution was stressed by James Henderson, the Headmaster of the Overtoun Institution, in 1903. Although at the time there was no hospital to speak of and no African nurses to help with the work, Henderson believed that a trained nurse-teacher could gradually develop both the educational and medical work. African agency would be crucial in this project: by "developing a native agency", Henderson believed that a nurse could "multiply her power" and would eventually be able to concentrate on the emerging hospital.[59] In 1905, the Institution employed two African dispensers and *"a very faithful hospital nurse"*, an elderly Christian woman by name of Maria.[60]

In Mwenzo, Chisholm felt that an experienced nurse was urgently needed in 1907. He offered to pay, with help from his friends, half of her annual salary of £120. Chisholm (whose wife was a nurse) argued that a nurse, who could gain the confidence of local women far more effectively than a doctor, would enable the mission to influence local midwifery practices and reduce child mortality. She would make it possible for Chisholm to perform complicated operations, acting as an assistant surgeon when needed. Furthermore, she would relieve the doctor of much of the ordinary dispensary work (including sterilising and cleaning instruments and looking after hospital patients) that the African assistants could not be "trusted with". This would, in turn, give Chisholm more time for his evangelistic, educational, and translation duties. Chisholm's offer was accepted, and Nurse Ballantyne took over the day-to-day running of the Mwenzo hospital in 1909, as well as the girls' boarding school and women's sewing classes.[61]

However, not all doctors asked for nurses to join their station. Elmslie believed in 1908 that the modest hospital of Ekwendeni would not require a nurse, at least for the foreseeable future, and that the nursing and feeding of patients could be largely left to their "friends and relatives". Elmslie argued that the most serious cases would be transferred to the David Gordon Memorial Hospital at the Institution.[62] However, by 1909 there was a general consensus

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57 McCallum to Smith 29 January 1900. NLS, Acc. 7548 D 69.

58 Livingstonia Mission Staff-Book. NLS. Acc. 7548 D 73. Rennick 2003, pp. 175-177.

59 Henderson 8 January 1903. NLS, Acc. 7548 D 70. Letters to the Livingstonia Sub-Committee 1903, pp. 45-46.

60 Fiddes, n.d. NLS, Acc. 7548 D 71: Letters to the Sub-Committee, 1905, pp. 38-39. At this time, when Laws was in charge of medical work, Fiddes devoted only about an hour of her day to medical duties.

61 Chisholm 29 November 1907. NLS, Acc. 7548 D 71: Letters to the Sub-Committee 1908, p. 29. *Annual Report for 1909,* p. 49-51.Rennick 2003, p. 140.

62 Elmslie 18 January 1908. NLS, Acc. 7548 D 71. Letters to the Sub-Committee 1908; Rennick 2003, p. 183.

among Livingstonia doctors that more nurses were required to make the new hospitals fully operational.[63] In the same year, Elizabeth B. Cole, a highly trained nurse with experience from the London Fever Hospital and Western Infirmary, Glasgow, was appointed. She was followed in 1913 by Ruth Livingstone-Wilson, Livingstone's granddaughter and a Certified Hospital Nurse with special training in midwifery. Miss Cole was to go on to become the first matron of the DGMH.[64]

There were clear economic reasons for the recruitment of fewer doctors and more nurses, especially after 1908 when the death of Lord Overtoun meant that the salaries of three missionary doctors had to be funded by some other means. An ordained medical missionary, with an annual salary of £330, was almost three times as costly as a nurse before the First World War. The salaries of European medical staff were a considerable source of expenditure at Livingstonia.[65]

In 1915, the Livingstonia Mission formally became one of the missions of the Foreign Missions Committee of the United Free Church, with one consequence being that "women's work" became a separate organisational sphere with separate finances and control. The Women's Foreign Missions Committee (WFM) now paid the salaries of Livingstonia nurses and female teachers. Laws was worried whether this meant that the WFM would take over all the hospitals in the mission, and insisted that the relationships between the doctors and nurses should to be made absolutely clear in order to guarantee the efficient functioning of hospitals. He was assured that doctors would remain in charge.[66] However, in 1922, for example, in the absence of resident doctors, nurses were fully in charge of hospitals and dispensaries at the Loudon, Ekwendeni and Tamanda stations. In 1924, Livingstonia had seven nurses on seven stations, although four of them were on furlough during that year. In the same year, eight mission doctors (plus Agnes Fraser) were employed but two of them were at home in Britain, Laws and Elmslie were in their seventies approaching retirement and only two, Wilson at Chitambo and Todd at the

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63 *Special Report. Livingstonia Mission Council, September, 1909, on Organisation and Expenditure.* Glasgow, n.d., pp. 24-26. NLS, Acc. 7548 D 71, Letters to the Sub-Committee.

64 Ruth Livingstone-Wilson worked in Chitambo between 1914 and 1919. In 1920, she married Rev. Alexander MacDonald, and remained at Chitambo station as a missionary wife. Livingstonia Staff Record Book. NLS, Acc. 7548 D 72; Moffat to Ashcroft 4 March 1920. NLS, MS. 7885, 47; McIntosh 1993, p. 169; Rennick 2003, p. 337. Not all Livingstonia nurses were Scottish. In the mid-1920s, a South African widowed nurse, Mrs Treu, joined the mission. Martin to "Uncle Frank" (F.Ashcroft) 11 October 1926. NLS, MS. 7889, 82.

65 In contrast, the Anglican UMCA in Malawi, which recruited mainly from the English middle classes, employed its staff as non-paid agents, a policy which, together with the insistence on celibacy, made recruitment particularly difficult but which resulted in considerable economic savings. Good 2004, pp. 295-308; McCracken 2000, pp. 272-273. During the early twentieth century the women's share of Scottish foreign mission work grew considerably and by 1930, the majority of all Scottish missionary agents were single women. Macdonald 2000, pp. 115-116.

66 Laws, "Women's work in the Livingstonia Mission". MNA 47/LIM/1/1/14, 208; Laws to Ashcroft 28 September 1914. MNA 47/LIM/1/1/14, 211; Ashcroft to Laws 1 December 1914. NLS, MS. 7681, 352.

Institution, were working as full-time doctors.[67] Furthermore, the Scottish home authorities preferred to assign the few recruited doctors elsewhere. When Andrew MacDonald expressed an interest in being appointed as a doctor at Livingstonia in 1920, he was told that the population in the region was small in comparison with West Africa and that there was a more acute need for doctors at the United Free Church mission in Calabar, Nigeria.[68]

During the 1920s, the missionary nurses had become central figures in missionary medicine at Livingstonia, and were, in addition to their hospital practice, increasingly undertaking child welfare work in their districts.[69] The lack of medical practice and the demands of non-medical work could, however, be a source of frustration for professional nurses as well as for doctors.[70] The training and employment of African medical assistants and nurses (discussed in detail in Chapter 10) was another crucial element that led to the development of hospital medicine in Livingstonia. By the 1920s, almost all the mission stations had one or more trained African medical assistants on their staff. In 1923, Chisholm, who had four medical assistants in Mwenzo, could write that medical practice was taking up little of his time, implying that medicine in Mwenzo was mostly practised by African assistants or a European nurse.[71]

The debate on mission hospitals

By the turn of the century, the younger doctors expressed a greater desire than the pioneers to concentrate on medicine and surgery, demanding that hospitals, nursing staff, and equipment be made available to them. They defended the hospital as an evangelistic agency, arguing that when the pioneer phase was over, hospitals would be needed in order to develop the medical practice in the established mission centres. Furthermore, they made it clear that medicine was their priority, profession and specialist field as missionaries.[72]

The younger doctors met with some opposition and reservations from the home authorities[73] as well as from older missionaries. In 1900, Elmslie argued

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67 *Report on Foreign Missions for 1922.*Nurses Cole at Loudon, Service at Lubwa, Reid in Itete (Tanganyika), Mary Patrick at Bandawe, Helen Patrick in the Institution, Christie at Ekwendeni, Ferguson at Karonga. Laws to Ashcroft 26 February 1924. NLS, MS. 7887, 23.

68 MacDonald 1964, pp. 37-38.

69 Maggs 1993, pp. 1309-1310; For example, Nurse Christie was in charge of medical work in Ekwendeni in 1924. Elmslie to Ashcroft 5 May 1924. NLS, MS. 7887, 49. Annual Report of the Provincial Commissioner for 1930, MNA S1/478/29.

70 Wilson to Laws 7 January 1925. MNA 47/LIM/1/1/35.

71 *Report on Foreign Missions for 1923,* p.102.

72 See, for example, the *Aurora* December 1900, p. 60. The importance of the hospital as an evangelistic agency was highlighted by Dr Caverhill of Blantyre in 1904. *The Nyasaland United Missionary Conference: Report of the Second General Missionary Conference,* Blantyre 15-24 October 1904, Blantyre Mission Press 1904, pp. 21-24. The younger Livingstonia doctors in particular seem to have been influenced and impressed by the developments at Blantyre. Blantyre had the most advanced hospital and medical education programme in the Protectorate at the beginning of the century. For developments in Blantyre, see Rennick 2003.

73 Rennick 2003, pp. 136-139.

that the Livingstonia Sub-Committee and Laws should explicitly consider the medical work of the mission and assess its importance and the resources allocated to it. The tendency to emphasise medical practice above all else was problematic for Elmslie not because of the value or necessity of the medical work, but because of the economic cost of establishing and running fully-equipped hospitals. He emphasised the difficulty of curtailing doctors' medical ambitions. The matter was also deemed to be important for staff morale: professional disappointment was regarded as the probable cause of the resignation of two Livingstonia doctors.[74]

In May 1902, the Mission Council discussed the medical policy of Livingstonia. The Council concluded that missionary medicine should be not only philanthropic, but also educational. Medical policy should be developed along the lines of industrial, educational and theological work. The Mission Council was keen to stress that medical practice was not mere philanthropy. However, instead of stressing its value as evangelisation, they presented medicine as one part of the mission's wide-ranging educational programme. The home authorities replied that while they understood the need for medical education in the central hospital, they were not willing to support such activities at other stations.[75] The Overtoun Institution (at this time still under construction) was the only centre of higher education within the mission and its development would limit the scope of district medical practice. The Institution hospital would become the centre for medical education in Livingstonia, and its main hospital. By January 1904 the first medical course was underway, although no permanent hospital had yet been established. The development of medical practice at the Institution was hampered by, among other things, the considerable administrative work required of Laws.[76]

Thomas Binnie of the Livingstonia Committee argued in 1911 that in their professional enthusiasm, the young doctors had forgotten the main purpose of the mission, namely evangelisation.[77] Money was an issue here: between 1875 and 1930 Western medicine progressed rapidly, but it also became increasingly expensive. New drugs were themselves expensive, but hospitals were particularly costly due to the trained staff and modern instruments required for more complex surgical operations and in-patient treatment. To the older supporters of Livingstonia, it was unclear if all this was worth the considerable investment that was needed. The new hospital medicine could perhaps cure

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74 Elmslie to Smith 31 January 1900. NLS, Acc. 7548 D 69; Rennick 2003, p. 138. The doctors were Robert Scott (resigned in 1900) and Alex. Brown (resigned in 1912 and transferred to the Indian Mission).

75 Minutes of the Mission Council 9-10 May 1902. NLS, Acc. 7548 D 70; Daly to Laws 10 September 1902. NLS, MS. 7864, 321.

76 Henderson 10 January 1904. NLS, Acc. 7548 D 70, Letters to the Sub-Committee, 1904, p. 43. *The Nyasaland United Missionary Conference: Report of the Second General Missionary Conference,* Blantyre 15-24 October 1904, Blantyre Mission Press 1904, p. 8. Until the appointment of Cullen Young as an accountant in 1904, Laws had been responsible for all the book-keeping at the expanding Institution. Cullen Young 8 May 1905. NLS, Acc. 7548 D 71, Letters to the Sub-Committee, 1905.

77 Minutes of the Mission Council 17 October 1911. MNA 47/LIM/3/17; Rennick 2003, pp. 135-136.

people more efficiently, but what was its evangelistic value? It is revealing that after Dr Prentice described an operation in 1899 in which a man was tapped for almost three hundred ounces of fluid from his abdomen, the doctor added: *"Our patient was very pleased with himself, and remarked he'd be able to attend the services now without being laughed at."* [78] The benefits of medicine and surgery for evangelisation and the church had to be explicitly stated in order to justify the specialised work of professional doctors.

In the pioneer stations, medicine, education and the gospel were advertised to the local population as being part of one package, as is evident in Dr Brown's description of Chitambo in 1907:

> The station is taking on quite a business-like and important air. We will say to the people, "Here is a school, come and be taught; here is a church, come and listen to the Word; here is a dispensary, come and be healed."[79]

In theory, there should have been no conflict within the holistic missionary approach where all departments served one common purpose. In practice, however, the medical department was causing increasing problems for the mission authorities during the first years of the twentieth century. The Livingstonia Committee was particularly concerned about Chisholm's practice at the new station of Mwenzo. In the early 1900s Mwenzo was the only Livingstonia station which provided regular medical care to local European colonialists and so had exceptional opportunities to collect local fees. Chisholm had to ensure that his role as an ordained missionary was not compromised by his medical practice.[80] The Foreign Mission Committee of the United Free Church reinforced their policy of ordaining missionary doctors, after their first term of service partly to curtail the professional ambitions of doctors.[81]

As Rennick has shown, there were important differences in the motivations, priorities and roles of the medical missionaries at Livingstonia, Blantyre and the UMCA in Malawi before the First World War. In her words, "the professionalizing and related secularising of mission medicine from 1900 onwards, was advanced by those medical missionaries who prioritised the professional rather than spiritual aspect of their role." These developments were most prominent in the Blantyre Mission main hospital, in response to the medical needs of the colonial economy in Southern Malawi.[82] In Livingstonia,

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78 Prentice to Smith 20 November 1899. NLS, Acc. 7548 D 69.

79 Brown 27 June 1907. NLS, Acc. 7548 D 71, Letters to the Sub-Committee 1907, pp. 81-82.

80 Daly to Chisholm 21 February 1902. NLS, MS. 7864, 188; Chisholm 30 June 1904. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee 1904, pp. 106-107; Rennick 2003, pp. 138-139.

81 In Karonga, Innes was reluctant to be ordained and was frustrated with the limits placed on his medical work. Rennick 2003, pp. 136-137.

82 Rennick 2003, pp. 320-321. Furthermore, the outstanding missionary doctor at Blantyre in the late 1890s, Neil MacVicar, was not allowed to carry out any religious teaching due to his doubts about some of the Christian doctrines. In consequence, MacVicar was able to devote all his time to medical practice and medical education of Africans far earlier than any of his colleagues at Livingstonia. See Ross 1996, pp. 169-171; Shepherd 1952.

doctors retained their clerical roles longer and the process of specialisation was slower than at Blantyre, regardless of the professional ambitions of doctors such as Prentice and Innes. Of the twenty-two male doctors appointed to Livingstonia between 1875 and 1914, only seven were not ordained at any point during their service, and of these seven doctors, six resigned, died or were invalided home during their first or second term of service.[83]

Despite the general pressure towards greater specialisation within medicine from the turn of the century onwards and an increasingly demanding medical curriculum in Britain, the traditional combination of medical and theological studies continued to be the norm for Livingstonia doctors in Scotland as well as in the field. In 1905, the Mission Council held that future medical missionaries should take theological classes alongside divinity students. However, there was a clear change in the proportion of candidates with dual qualifications. The majority of twentieth-century Livingstonia doctors did not have a degree in theology (unlike many early doctors including Laws, Stewart and Cross), but after some time in the field (usually during their first term at Livingstonia) they would be ordained. Prentice, Chisholm and Innes were all ordained after their first term.[84]

It seems that by 1909the younger doctors had managed to persuade the old guard to re-evaluate the mission's medical policy. All the doctors on the Mission Council argued unequivocally that the importance of medicine should be recognised by the Livingstonia Sub-Committee and developed accordingly. Medicine should be *"never be gauged by the view that only as it opens doors, or gains an advantage over other religions is it a branch of service which the mission is justified in supporting."* The Committee should not fix upon a maximum number of staff or amount of equipment, but should regard the current situation as a "distressful minimum", to be rectified when more funds became available. The doctors stressed the fundraising potential of the image of the suffering African being healed by missionary medicine within the missionary appeals, arguing that the interest, sympathy and funds generated by such work benefited all branches of missionary work.[85] At a time of increasing financial difficulties for the mission this was the rhetorical strategy employed by the doctors. They were afraid that the home authorities would, in their fear of extra expenditure, stifle their medical practice, which despite the overall financial problems of Livingstonia could occasionally be improved and expanded with new funds generated specifically through medical missionary appeals.

During the first decade of the twentieth century, the traditional idea of medical mission as primarily a pioneering missionary agency and a weapon against indigenous medico-religious practices was increasingly contested in Livingstonia, and not merely among the doctors. At the United Missionary

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83 See Appendix 1. The exception was Dr Hubert Wilson (appointed in 1914).

84 Minutes of the Mission Council 20 April 1905. NLS, Acc. 7548 D 71, Letters to the Sub-Committee 1905, p. 51. Livingstonia Staff Record Book. NLS, Acc. 7548 D 72.

85 *Special Report. Livingstonia Mission Council, September, 1909, on Organisation and Expenditure.* Glasgow, n.d., pp. 24-26. NLS, Acc. 7548 D 71, Letters to the Sub-Committee.

Conference of 1904, while James Henderson was concerned that mere dispensing of medicines without emphasising Christ as a healer would dangerously lead *"the native to believe in the healing properties of drugs as such"*, Donald Fraser stressed the scientific basis of missionary medicine and argued that the *raison d'etre* of medical missions *"was not to break down superstitions, but to relieve suffering."* Laws as the chairman presented a compromise position, stating that, *"there was no greater joy than to talk at the bed-side of a sick native about the Lord Jesus Christ"*.[86]

The Livingstonia doctors in 1909 explicitly stated the importance of medicine in saving lives, and in a way were indirectly criticising the policies and priorities of Laws: *"…we certainly ought not to spend more in training natives to make furniture than we do in order to give health to the multitudes who would perish but for the aid we give*."[87] It is significant that the saving of African souls was not mentioned at all here. "Giving health" was presented as being valuable in itself, something that missionaries such as Henderson were suspicious of, believing that it could lead towards secularisation in matters of illness, health and healing. Despite opposition, during the 1900s and 1910s medical practice in Livingstonia expanded and became more professional with the establishment of hospitals, medical education programmes and public health campaigns. By raising funds specifically for medical purposes, for hospital construction for example, doctors such as Prentice could overcome the home authorities' resistance to medical expansion to some extent.[88]

Among the early twentieth-century medical missionaries, there was potential for conflict between their medical and clerical roles, not only in the foreign field, but also during their furloughs in Scotland. Prentice argued in 1903 that missionary doctors should not be required to undertake deputation work (taking part in tours of the Scottish congregations preaching and gathering funds) which should be left to ordained missionaries. Instead, doctors should be required to renew and refresh their medical skills by attending hospitals and taking classes and "cliniques" whenever possible. This should be a doctor's first priority. For Prentice, overzealous missionary doctors should be kept in their proper sphere, i.e. medicine. He did not have much faith in the doctors' abilities as preachers, and he doubted that their addresses to the congregations would do the mission cause much good.[89] Whilst arguing the case for a hospital grant for Kasungu, Prentice resorted to military metaphors,

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86 *The Nyasaland United Missionary Conference: Report of the Second General Missionary Conference,* Blantyre 15-24 October 1904, Blantyre Mission Press 1904, pp. 28-29. Fraser, possibly in accordance with the views of his wife, argued that the main motives for medical missionary deployment in Africa were not, as in Asia, evangelistic, but philanthropic and practical: to sincerely imitate Christ in healing and to secure the health of fellow missionaries. See statement by Fraser, in *Annual Report for 1905*, p. xiv.

87 *Special Report. Livingstonia Mission Council, September, 1909, on Organisation and Expenditure.* Glasgow, n.d., p. 24. NLS, Acc. 7548 D 71, Letters to the Sub-Committee.

88 Rennick 2003, pp. 158-159.

89 Ibid.; By this time, Prentice was suffering from an unspecified throat condition which prevented or limited his preaching in the field. Minutes of the Mission Council 25 October 1898. NLS, Acc. 7548 D 69.

claiming that medicine and surgery were his "strongest weapons" to be wielded against *"the cruelties and superstitions of this land."*[90] His fear was that without necessary practice, these weapons would rust. At a time of rapid medical advance, missionary doctors without sufficient practice could be left behind, and the invocation of African "cruelties and superstitions" as the doctors' enemies was central to Prentice's rhetoric.

When Dr Brown suddenly resigned in 1912 on the grounds that there was insufficient medical practice in Chitambo, Laws wrote to his colleague asking him to reconsider his decision. Laws admitted that there was much more medical work in the medical missions in Asia and sympathised with Brown's professional frustration, writing that he had experienced similar feelings himself. However, Laws argued that a small hospital was actually more effective for conversion purposes than a busy major hospital.[91] For Laws, smaller hospitals with fewer patients allowed greater scope for more intense evangelisation and contact between the physician and the patients. Following Brown's resignation, Laws wrote to Hubert Wilson, a medical candidate, reiterating the need to put missionary work before medical practice, and stressed that Livingstonia was not India or China in terms of medical possibilities. He then described what Wilson's role would be in Chitambo:

> … as medical missionary the care and treatment of the sick would be your first duty, not as a medical officer merely, but as a medical missionary, seeking to lead your patients to Christ. Next, you would probably share with… the ordained missionary as might be mutually arranged, the care of services at outstations, or on the station in his absence, and also in superintending the schools in this district or helping when the teachers' school is held on the station. Generally, an African missionary has to be ready to lay his hand to any work needing to be done...which will give him the opportunity of serving his Master...to my mind an individual who would shirk manual or any other work would shew himself to be a poor follower of the Carpenter of Nazareth.[92]

Only in the main mission centre at the Institution, were medical graduates expected to be full-time doctors in 1912. In Scotland, the idea that in the African field clerical missionaries could realise their full masculine potential as builders, teachers, mechanics, and linguists as well as doctors, still had some currency in the 1920s and it was presented as one of the most effective ways of attracting young clergymen to the foreign field.[93] In turn, the image of the male medical missionary as a particularly versatile "superman" is particularly apparent in the description of Prentice in the Free Church *Record*:

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90 Prentice 9 May 1907. NLS, Acc. 7548 D 71, Letters to the Sub-Committee 1907, p. 69. Prentice had begun his career at Bandawe, where the station had been headed by MacAlpine, and he had been able to practice medicine to a greater degree than most of his colleagues. Prentice's professional commitment to medicine is highlighted by the fact that when he was approaching retirement age, he wanted to spend his last working years in mission as a "doctor with a roving commission". Prentice, "memorandum", n.d. NLS, MS. 7886,101.

91 Laws to Brown 13 January 1912. MNA 47/LIM/1/1/13, 751.

92 Laws to Wilson 13 January 1913. MNA 47/LIM/1/1/14, 54.

93 Minutes of the Mission Council 18 October 1912. MNA 47/LIM/3/17; *The Record,* April 1921, pp. 119-120.

> Dr Prentice is a most versatile man. He is of course, first and foremost, a missionary doctor, with a great reputation, especially for eye cases…Then he is a great gardener…He is besides…an expert of tropical diseases…Then he is a great hunter…And he is a great mechanician…He plays, too, both organ and fiddle…[94]

In this image, the old heroic images of the missionary as hunter, doctor and pioneer were combined with the more modern elements of professional specialisation, scientific and technical expertise, not forgetting the artistic side of a creative missionary. In post-First World War Scotland, foreign missionary work was suffering from an acute lack of recruits, funding and enthusiasm, and the images and writings of the *Record* at the time have to be placed within this context.[95]

The policy of ordaining doctors continued at Livingstonia after the war, but it gradually became less prominent. The total number of doctors also decreased: in 1926, following one new recruit's resignation after his conversion to Catholicism and Laws' final retirement from medical practice, Chisholm believed there were fewer medicals "than ever before". Of the four doctors appointed to Livingstonia in the 1920s, two also became ordained ministers,[96] but it seems that by this time the ordination of doctors was becoming more the exception than the rule. The Union of Churches in Scotland in 1929 meant that Livingstonia formally became part of the Scottish Presbyterian foreign mission, and its unique status and policies in medicine, as in other departments, were gradually eroded.

Dispensaries and hospitals in the early 1900s

Cross and Prentice were especially active in the development of medical facilities at Livingstonia in the mid-1890s. Cross built a small hospital in the "native fashion" in Karonga in 1895. It was not until the 1900s, however, that Livingstonia's dispensaries began to develop into a network of small brick hospitals: Mwenzo (1903), Ekwendeni (1907), Kasungu (1910) and the far more ambitious David Gordon Memorial Hospital (DGMH) at the Overtoun

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94 *The Record,* April 1924, pp. 163-166. It should be noted that aside from his medical practice, Prentice's roles as hunter and gardener could also be seen to serve the causes of public and preventive health. His orchard and garden at Kasungu were recognised as "valuable assets to health". Transfer minutes of Kasungu. NLS, MS. 7886, 92. The missionaries actually referred to each other as "supermen" in front of both Africans and Europeans. *The Record* March 1924, pp. 111-112. For Alexander Caseby, recruited after the war, Robert Laws was unquestionably a superman, a hero of Central African history. AUL, MS. 3289. Caseby Papers, No. 2.

95 See, for example, *The Record* December 1926, p. 542 for Donald Fraser's lament about the lack of missionary candidates.

96 Chisholm to Ashcroft 12 June 1926. NLS, MS. 7889, 41; Sinclair 2002, p. 249. One of these recruits, David McCulloch Brown, was ordained before appointment, and had been in home mission service in Orkney, while Dr George Binnie Burnett was ordained in 1932, after his first term of service. Livingstonia Staff Record Book. NLS, Acc. 7548 D 72.

Institution (1911).[97] Laws' ambitious building, industrial and educational programmes meant that the medical department at the Institution developed slowly. The progress was slow elsewhere, too, and this was a constant source of criticism for the younger missionary doctors. In August 1900, a writer in the Livingstonia magazine *Aurora* lamented that regardless of its many doctors, Livingstonia was "*one of the most meagrely equipped medical missions at the present time.*" He argued that it was time to improve the medical practice at Livingstonia by following the model of Indian medical missions. A good central hospital should form the hub of branch dispensaries, medico-evangelistic tours and training for African medical evangelists.[98]

In October 1900, the Mission Council acknowledged that medical mission work should be emphasised, not only on the pioneer stations but also in "*confirming & strengthening the life of the native church*". Furthermore, all principal stations should establish proper "native hospitals".[99] This policy was implemented slowly over subsequent years. Following large-scale African conversion, medical missionaries would increasingly serve the Christian population around the old stations, and the role of missionary medicine would shift from "opening doors" and preparing the ground for conversion to the provision of medical services in order to keep the Christian community healthy and away from indigenous medico-religious beliefs and practices.

In Mwenzo, Chisholm was able to build a small brick hospital remarkably quickly due to the medical fees paid by Europeans in the district, especially the BSAC employees.[100] By 1902, Chisholm was able to draw up plans for a hospital with "*two wards of four to six beds each, and central building divided into dispensary, waiting-room, and operating-room*", to be paid for from local subscriptions and fees.[101]

During the period 1902-14, Mwenzo was an exceptional station in that its local fees and subscriptions usually more than covered local medical expenses. Between 1905 and 1907, and in 1909, for example, Mwenzo provided over half of all the local medical income of the mission. Hospital funding elsewhere in Livingstonia was largely based on subscriptions from Scotland.[102]

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97 Rennick 2003, pp. 227-229.

98 The *Aurora* August 1900, p. 35; *Annual Report for 1902,* p. 9.

99 Minutes of the Mission Council 29 October – 2 November 1900. NLS, MS. 7883.174.

100 Chisholm 14 July 1901. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee 1901, pp. 33-34. The Administration offered Chisholm £10 as a nucleus for the hospital in Mwenzo, and the Livingstonia Mission Council gave him permission to construct a small hospital. During 1901, Chisholm took over £100 from European patients in medical fees, more than the entire medical expenditure for the year. See Chisholm 3 January 1902. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee 1902, pp. 5-6. The majority of these fees were for the continued treatment of two complicated cases.

101 Chisholm 10 April and 14 June 1902. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee 1902, pp. 33-35, 44-47.

102 *Annual Reports of the Livingstonia Mission*, 1902-1914. Money transfers, delays and changes in plans sometimes led to confusion and delays in construction. See, for example, Laws 28 May 1902. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee 1902.

The heads of stations presented their plans for hospitals in May 1902. Most stations (Mwenzo, Kasungu, Karonga, Ekwendeni and Loudon) proposed the construction of eight-bed hospitals. At Bandawe, the original plan of a twenty-bed hospital was scaled down to twelve beds and at this stage the Institution hospital was to have not more than twenty beds. The estimates of costs and funds available varied from station to station. Bandawe already had £380 available, Mwenzo had over half of the estimated £120 needed in local subscriptions, while Elmslie, at Ekwendeni, thought the hospital would cost no more than £20, as he would be able to use free labour. Similarly, Donald Fraser, who was planning a new station in uNgoni, stated that a small hospital could be built using free local labour, but did not give any estimates of further costs. By comparison, the overall building work at the Institution would prevent immediate hospital construction, and the establishment of a hospital there was dependent "on other circumstances" i.e. funds, labour, and time available. At this time, the cost of this project was estimated to be around £500.[103]

In uNgoni, the missionaries relied upon free labour to erect hospitals. In Loudon this was provided by the chief Mzukuzuku, and the station was known to the Ngoni as "Mzukuzuku's mission". This seems not to have been the case in Bandawe and Kasungu. In Bandawe, MacAlpine praised the activism of local Christians who built the brick school and church buildings for free. By comparison, the hospital was funded through the sale of Dr Boxer's bricks, local donations and missionary legacies, but no mention was made of free labour.[104] Perhaps at this time the church and school were more highly valued than a hospital in Bandawe, but it should also be noted that the Tonga society was far less centralised than the Ngoni communities. In uNgoni, ruling chiefs who were sympathetic to the mission, could command the necessary labour to erect an entire mission station. Furthermore, the Tonga and the Chewa were at this time paying colonial taxes, which was not yet the case in uNgoni.[105]

The Bandawe hospital, completed in 1908, consisted of a central block and with ward accommodation on either side, men on one wing and women on the other. The central section consisted of an outdoor dispensary and behind it a small operating room and drug store. The building was 135 feet long but comparatively narrow, and cost the mission £212. In the outer blocks there was a prayer hall on the men's wing and a maternity on the women's side.[106]

In Ekwendeni, Elmslie built a small cottage hospital around the dispensary. In 1908, the hospital was nearing completion, and consisted of *"two detached cottages of two rooms each, of well-burnt and well-built bricks and roofed with tiles."* According to Elmslie, the design of separate cottages suited the prevailing arrangement whereby patients were cared for largely by their friends and relatives. With the additional construction of small outhouses and an enclosing

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103 Minutes of the Mission Council 9-10 May 1902. NLS, Acc. 7548 D 70.

104 MacAlpine to Binnie n.d. (September 1908). NLS, Acc. 7548 D 71. Letters to the Sub-Committee 1908, pp. 146-148; Thompson 1995, p. 133.

105 See Vail 1983.

106 Robertson 7 September 1908; MacAlpine to Binnie n.d. (September 1908). NLS, Acc. 7548 D 71. Letters to the Sub-Committee 1908, pp. 130-132; 146-148.

wall, Elmslie advised that the cost of the whole hospital would not exceed £150.[107]

The Frasers received a donation from Mrs Loudon to construct a hospital at their new station (to be named after the Loudons) but Donald Fraser explained that they did not need a large hospital, as they had no nurse at the station. In January 1903 he argued that the ideal would be for local people to build the small cottage hospital that his wife needed. Fraser believed that a European station built with European money would pauperise Africans and anchor the Europeans to it. Instead, when people built the hospital for themselves they would regard it as their own, and take responsibility for it.[108]

It appears that the gift of £500 from Mrs Loudon was primarily intended to fund a larger hospital. Fraser, however, refused to commit to spending the total sum on a hospital. He argued that it would paralyse the overall mission work at the station and furthermore that without more medical staff, a large hospital would be useless. Finally, he stated that as a husband he would not allow *"such a vast addition to the work of my wife"*. For Fraser, the mission should not let the donors dictate the plans and work of the resident missionaries.[109] In the case of Loudon, where a considerable sum of money for the hospital was at hand, the lack of an allocated nurse and the fact that Mrs Fraser was regarded primarily as a missionary wife and only secondarily as a doctor limited the potential scope of the hospital.

At the pioneer stations, the order of building varied. Prentice described the situation in Kasungu in 1903 when he estimated that the construction of the entire station would require funds of around £1,000. The entire station was to consist of a dwelling-house, church, school, and dispensary built using locally-made bricks. When more funds became available, Prentice would build a hospital. He pointed out that unlike the situation in Mwenzo, in the Kasungu area there were no Europeans whose medical fees could support the station.[110] In contrast, in Mwenzo with its initially lucrative European practice, Chisholm had to reassure the Committee repeatedly that medical practice was not taking over other branches of mission work. The photograph of the large hospital building had caused some anxiety in Scotland, and Chisholm had to point out that one of the blocks of the building was being used as a boarder's house and classroom. He added that if he had not had so many local donations given solely to fund the construction of the hospital, a smaller building would have been sufficient for his medical practice. After three years, the station still did not

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107 Elmslie 18 January 1908. NLS, Acc. 7548 D 71. Letters to the Sub-Committee 1908.

108 Fraser 6 January 1903. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee 1903.

109 Fraser 17 March 1903. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee 1903. Fraser's brother had drawn up plans for hospital buildings, which he assured, would not cost much more than a hundred pounds. In contrast, Fraser was planning to build a large European dwelling-house, which Laws had feared could cost over £700. However, Fraser assured the Committee that it could be constructed much more cheaply by minimising the work of expensive European artisans.

110 Prentice 27 June 1903. NLS, Acc. 7548 D 70, Letters to the Sub-Committee, 1903, p. 102.

have a church.[111] This was in marked comparison to the developments in uNgoni.

By Christmas 1903, Donald Fraser could report positive developments at the emerging Loudon station. The station consisted of a store, office, tool-house, a boarder's house (where the Frasers lived temporarily), an African pastor's house, hospital, church, and houses for joiners and builders. Trees had been felled around the station, the ground had been cleared, and short roads had been built. The "good-sized" hospital consisted of "*two wards, waiting-room, operating-room, dispensary, surgical dressing-room, and two nurses' rooms*".[112] Fraser claimed that the new church was the largest in British Central Africa, and that it could house a congregation of three thousand people. In the construction of the station, four thousand people in the neighbourhood had given a fortnight of free labour, and the cost of the buildings to date was around £1,100, which apparently included the £500 originally intended for the construction of the hospital. Only the missionaries' dwelling house remained unbuilt. The news of Agnes Fraser's hospital soon spread through uNgoni. By June 1904, Charles Stuart reported that people from the Ekwendeni area were travelling to Loudon for operations – a distance of over sixty miles. By August, Fraser reported that the brick hospital had been fully occupied since it had been opened. There was room for a maximum fourteen beds, and two or three rooms for special cases.[113]

The order of building at the various stations depended on specific locality, available resources, mission policies and personnel. In Loudon, the first buildings constructed were the combined church-school and the hospital, in Mwenzo a joint hospital and school and in Kasungu, a house, a school, and a dispensary. Unlike the situation at the Ngoniland stations, Prentice was not able to draw upon free local support and labour in Kasungu and was cautious about the likelihood of receiving "thank-offerings" from the patients and their families. In uNgoni the missionary presence had a longer history, there was a significant Christian revival and there was sympathy towards the mission from the chiefs, who, as yet untaxed by the colonial authorities, provided Fraser with free labour.[114] In comparison, in Kasungu, Prentice had worked for only three years among the mostly Chewa-speaking population who had been hitherto distant from mission Christianity. Prentice had been so consumed by his other work that his medical practice had been limited, as was its value as an advertisement for the mission.

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111 Chisholm 30 June 1904. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee 1904, pp. 106-107. The medical fees taken from Europeans diminished significantly in Mwenzo after the war however. In 1922 Chisholm reported that since the Boma had moved sixty miles to the south, he had received no medical fees at all. Chisholm to Fraser, n.d. quoted in *The Record,* May 1922, p. 170.

112 Fraser 24 December 1903. NLS, Acc. 7548 D70, Letters to the Sub-Committee, 1904, pp. 38-40.

113 Ibid; Stuart 13 June 1904; Fraser 2 August 1904. NLS, Acc. 7548 D70, Letters to the Sub-Committee, 1904, pp. 131-132, 139-141.

114 McGregor 4 October 1904. NLS, Acc. 7548 D 71: Letters to the Sub-Committee, 1905; Thompson 1995; Vail 1983.

In 1903, Livingstonia received ten times the money originally thought adequate to build a central Institution hospital. Two sisters in Scotland donated £5,000 towards a hospital to be named after their late brother David Gordon, a would-be medical missionary. This unexpected gift meant that the mission had to completely alter its Institution hospital plans. Before the hospital finally opened in 1911, mission authorities had to reassure its donors several times that work was actually proceeding. They emphasised that the hospital would require proper planning, especially the water supply, heating and sanitary system. Even when the hospital was ceremonially opened, it was only partially completed. However, at the time, the DGMH was regarded as the most advanced hospital within the Protectorate. When completed, it consisted of two ward pavilions, one on each side, and a central block, which boasted consulting-rooms, an out-patient department, an operating theatre and laboratory, as well as a sterilising and recovery room.[115]

By 1909, the mission had six hospitals of various shapes and sizes (the DGMH at the Institution, Mwenzo, Bandawe, Ekwendeni, Loudon and Kasungu) with a combined total of over fifty in-patient-beds. Only Karonga and Chitambo were without a hospital, and the funds were available to construct hospitals at these stations. However, the Livingstonia doctors now pointed out that the hospitals could not be as effective as they should be until they were provided with nurses and doctors who were able to devote more of their time to medicine. The number of beds increased to eighty-five in 1910 and one hundred and two in 1913, before dropping to seventy-five in 1914, when the outbreak of the war hampered work in the northern stations, and the Loudon hospital was destroyed by fire. In 1913, the DGMH had thirty-five beds, while the smaller hospitals had between three and eighteen beds. After the war, new temporary hospitals and dispensaries in Tanganyika were built on an extremely meagre budget. In 1923, Dr Brown reported that in Tukuyu a brick hospital with ten beds had been erected at the cost of only ten pounds.[116]

4.3 Medicine, surgery, and patients, 1900-1929

Missionary medicine and surgery in the early twentieth century

Although the turn of the century witnessed significant paradigmatic changes in Western biomedicine, the bulk of medical practice at Livingstonia remained similar to that of the 1880s. Dispensing simple medicines, dressing ulcers and

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115 *Proceedings and Debates, 1903*, p. 46; Elmslie to Laws 10 November 1904. NLS, Acc. 7548 D 67; *FCSMR,* January 1912, pp. 15-16; Rennick 2003, p. 229.

116 *Special Report. Livingstonia Mission Council, September, 1909, on Organisation and Expenditure.* Glasgow, n.d., pp. 24-26. NLS, Acc. 7548 D 71; *Report on Foreign Missions for 1909*; *Annual Reports* for 1905-1914, Statistics No. VI; Laws to Mrs Fraser 27 May 1914. MNA 47/LIM/1/1/15, 761; Brown, quoted in *Other Lands,* October 1923, pp. 35-36.

minor surgery remained the most prominent features of medical practice.[117] Drugs, instruments and medical expenditure did not change radically, although injections, for example, were gradually becoming more common. However, with the establishment of permanent hospitals and the employment of nurses and medical assistants, missionary medicine was gradually reorganised and centralised.

Medicine chests were among the most important and expensive possessions of missionary doctors, and were often supplied by individual donors or organisations. In 1900, Prentice described his medicine chest as a "portable dispensary" and he argued that a doctor coming to the field should also have *"the ordinary hypodermic case, a serum syringe… and a good supply of the bi-hydrochlorate of quinine."* [118]

However, a recently-arrived doctor would often, in practice, be severely hampered by a lack of medicines and instruments. For example, in 1901, Ernest Boxer wrote that immediately after he took charge of medical work at Bandawe, he was able to accomplish very little because Prentice had taken almost all of the surgical instruments with him to Kasungu. Boxer estimated that the annual medical costs for the year at Bandawe would be £50, of which half would be spent on freight expenses. Of the remaining £25, he thought that £10 would need to be spent on the maintenance of the dispensary and the salary of the skilled medical assistant, leaving only around £15 for new instruments. Boxer regarded the sum of £50 to be exceptionally high, but absolutely necessary to secure European health at the station in case of emergencies, and he appealed to Lord Overtoun for these funds. Fifty pounds was regarded to be an adequate sum for a medical "outfit" for a new doctor as late as 1920.[119]

The annual costs of the dispensary and hospital medicines varied. In 1901, the annual cost of medicines in the Institution was just £12, while in 1903 it was £50. In 1903 the fire which destroyed the Ekwendeni dispensary including all medicines and most surgical instruments represented an estimated total loss of £240. Elmslie stated in 1908 that the annual upkeep of the Ekwendeni dispensary had been between ten and fifteen pounds during previous years (1901–07). He expected that the hospital would not add more than forty shillings to the annual costs, which would be spent on of blankets and food for the few "friendless patients".[120] The majority of in-patients were looked after by their kin therapy management group: this co-operation was economical for the

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117 Medical Report for 1895. NLS, MS. 7878, 304; *Report on Foreign Missions for 1899,* p. 99; *Annual Reports, 1900-1905.* In 1904, Agnes Fraser reported that she had treated a number of emaciated ulcer patients during the rainy season with regular dressings and "plenty salt and tonicing". *Annual Report for 1904,* p. 34.

118 Prentice to Smith 3 July 1900. NLS, Acc. 7548 D 69. Prentice treated both African and European fever cases with quinine injections. *Livingstonia Mission Report for 1899-1900,* p. 16.

119 Boxer to Overtoun 5 November 1901. NLS, Acc. 7548 D 70; Turner to Ashcroft 10 December 1920. NLS, MS. 7885. 13.

120 *Annual Reports for 1901,* p. 29; *1903,* p. 33; Overtoun Institution and Home Account (General) for 1903. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee 1904, pp. 120; Elmslie 18 January 1908. NLS, Acc. 7548 D 71. Letters to the Sub-Committee 1908.

missionaries and provided patients with social and material security from their relatives.

Despite reports of occasionally challenging surgical operations in the 1890s, surgical practice in Livingstonia remained modest in both scale and scope. Prentice admitted that he felt envious when he heard reports of the operations performed by a fellow medical missionary in China, while he needed to administer chloroform only twice in twelve months at Bandawe during 1899. The basic surgical equipment and the limited supply of surgical lint, among other shortages, curtailed surgery to the extent that dispensing drugs remained the central feature of Prentice's practice.[121]

A wider range of medicines were available to missionary doctors by the 1890s, although the budget for medical purchases remained meagre. Cross' 1895 order for medicines at Karonga, at a time when he had probably the largest medical practice in Livingstonia, reveals interesting details about the missionary doctor's pharmacy at the time. He ordered fifty different articles, (most in the form of pills or tabloids), including five hundred tablets of soluble quinine and two hundred "antimalaria pills"; morphine, apomorphine and cocaine were ordered for hypodermic injections, as well as six eight-ounce bottles of chloroform (one year's supply). Drugs to treat venereal disease were prominent within his order: eight hundred "antigonorrhoea" and five hundred "antisyphilite" pills.[122]

At the turn of the century, missionary medicine was largely administered orally. The doctors prepared "stock-bottles" of medicine for the most common ailments, which could be readily dispensed by the doctor, assistant or nurse.[123] Before the First World War, the most effective drugs in mission dispensaries in Central Africa were quinine, morphia, chloroform, local anaesthetics, digitalis, antiseptics, and lymph vaccine. The Livingstonia doctors' most powerful "tonics" included arsenic, iron and strychnine, and mercurial compounds were still widely used. As Good has noted, few Africans in Malawi, before the 1920s at least, had access to systematic treatment using the most expensive drugs.[124]

While the doctors' professional interest focused on the new "tropical" diseases, the majority of patients were treated for fever, chest diseases, diarrhoea, dysentery and other intestinal illnesses. On the surgical side, ulcers and abscesses were the most common complaints, with missionaries occasionally operating on patients with injuries resulting from accidents or wild beasts.[125] The most important drugs remained the same as those from the late

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121 Cross to Smith 8 January 1895. NLS, MS. 7878, 24; *Report on Foreign Missions for 1899*, pp. 98-99.

122 "Copy of list of medicines for 1895" in Cross to Smith 12 May 1894. NLS, MS. 7877, 90. During 1894, Cross reported having treated seventy-one cases of "impure disease", see Cross to Smith 8 January 1895. NLS, MS. 7878, 24. Undated "List of Medical Stores at Livingstonia Mission" contains about 180 different articles. Wellcome Institute Library, MS. 3187; Rennick 2003, pp. 106-108.

123 Chisholm 30 June 1904. NLS, Acc. 7548 D 70, Letters to the Sub-Committee 1904, pp. 106-107.

124 Good 2004, p. 398; Laws to A. Fraser 9 April 1919. MNA 47/LIM/1/1/19.

125 *Annual Reports* for 1902, p. 37; 1905, pp. 19-12; 1909, p. 31; 1911, pp 10-12; 1913, pp. 13-15. Chisholm 30 June 1904. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-

nineteenth century. Quinine had become the standard treatment for fevers, and was also used as tonic. In 1912, Laws believed that quinine was becoming increasingly well-known and popular among Africans, who *"apply for it, though few are heard to say it."* To combat dysentery in 1917, Laws used pulvered ipecac and, in serious cases, also opium.[126]

In his treatment of influenza in 1919, Laws used "Tinct. Strophanthus", a local drug, for cough and "quinine & Ammon.Carb." together with "an expectoran with some Tinct. Camph. Co". While fighting influenza in uNgoni, Agnes Fraser requested hypodermic syringes, carbolic, quinine, boric acid, castor oil and magnesium sulphate. Castor oil and magnesium sulphate, in particular, were expensive drugs in the Protectorate.[127] Freight costs continued to make drugs and instruments costly. Dr Brown wrote from Tanganyika in 1922that he had only around £55 left of his medical budget and that he would be left penniless if he had to pay all of the transit fares.[128]

As hospitals became established, the need for new instruments and equipment grew more acute. In 1906, Dr Brown argued that the most important item for the planned new hospital in Bandawe would be a Pasteur Chamberland water filter. By 1917, the David Gordon Memorial Hospital had been equipped with a steriliser and an incubator.[129] The electrical supply at the Institution enabled the use of the newest medical technology at the DGMH. After the war, the missionary doctors planned to purchase surgical instruments from war stocks, but they were too expensive. In 1919, the Foreign Missions Committee informed Laws that it was not possible to provide expensive surgical apparatus to the mission hospitals. An X-ray machine was not installed at the DGMH until 1927. This was the first in the Protectorate, purchased with funds collected from Scottish Sunday Schools.[130] Special donations continued to be a crucial source of medical and surgical paraphernalia throughout the period, as the mission budget did not allow for major new acquisitions. In 1926, Livingstonia received the gift of an operating table through one of its nurses "from friends in Dundee and Dunkirk". This new table was regarded as a

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Committee 1904, pp. 106-107. In 1902, Agnes Fraser reported that ulcers comprised "*quite half our total cases.*" Brown has noted how in the British colonial hospitals in Lagos between 1861 and 1905, the clearly "tropical" diseases were a minority in comparison to those that could also be found in temperate regions. The most common disease categories there included ulcers/abscesses, fevers, digestive complaints/dysentery and smallpox. Brown 2004, p. 332.

126 Laws to Dr Hearsay 23 March 1912. MNA 47/LIM/1/1/13, 924; Laws to Innes 6 February 1917. MNA 47/LIM/1/1/17, 827. In early nineteenth-century medicine the ipecacuanha root was known and used to induce vomiting. Honigsbaum 2001, p. 18.

127 Laws to A. Fraser 9 April, 7 May and 13 May 1919. MNA 47/LIM/1/1/19, 11, 61, 68. Strophanthus was a local drug produced for export in the Protectorate. Exports peaked in 1906 with sixteen tons worth £8,000. Baker 1971, pp. 96-97.

128 Brown to Ashcroft 15 March 1922. NLS, MS. 7885, 101; Rhubarb pills were cheaper than magnesium sulphate, and were still in use well into the 1920s. Laws to Faulds 27 September 1926. MNA 47/LIM/1/1/25 (a), 679.

129 Brown 10 December 1906. NLS, Acc. 7548 D 71. Letters to the Sub-Committee 1907, p. 10; Laws to Innes 19 February 1917. MNA 47/LIM/1/1/17, 850.

130 Laws to Ashcroft 2 June 1919. MNA 47/LIM/1/1/18, 54; Ashcroft to Laws 25 September 1919. NLS, MS. 7684, 860; King and King 1991, p. 45, in Good 2004, p. 402.

"great boon" to operations in the DGMH, which had been previously performed on an old wooden table.[131]

Arguably the most important development in colonial medical practice in Africa during the 1920s and 1930s was the introduction of the arsenical compounds Salvarsan and neosalvarsan, which were remarkably effective injections to used treat syphilis and yaws. The injections made those rural dispensaries and clinics that could provide them unprecedentedly popular. In Maryinez Lyons's words, "For the first time, Africans were offered a relatively painless and effective Western medication".[132] However, at least in 1919, these drugs were too expensive for Livingstonia's limited medical budget. In 1926, the *Other Land* –magazine celebrated the new use of yaws injections by Scottish missionaries in Calabar, but it is unclear at which point neosalvarsan injections become widely available at Livingstonia.[133]

Medical touring and mobility

Medical itineration continued to be part of the doctors', nurses' and to some extent, lay missionaries' work in the twentieth century. Laws visited the sick in the villages around the Institution, conversing with them, providing medicines and inviting serious cases to the hospital for treatment.[134] While the missionary doctors concentrated upon hospitals, they noted that the African population was spreading out away from the mission centres in many areas, notably at Bandawe but also in Ngoniland and Sengaland.[135]

The mobility of missionaries improved considerably during the early 1900s due to improvements in roads and transport. Laws noted that while in 1898 it took him thirty-two hours in a medical emergency to reach Karonga from the Institution the same trip took only eighteen hours in 1905. In 1907, Chisholm was able to cycle over a hundred miles in little over twenty-four hours to assist an LMS doctor with an emergency case.[136] The improved mobility, especially after the acquisition of motorcycles, made medico-evangelist tours less time-consuming and enabled doctors to assist their colleagues in emergencies and difficult operations more often. In 1913, Prentice wrote a report of a successful ovariotomy operation he performed with Turner

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131 *The Record,* July 1926, p. 357.

132 Lyons 1994, p. 207.

133 *Other Lands,* April 1926, p. 99. In Nyasaland, the UMCA provided large-scale arsenical injections from about 1920, while the White Fathers considered the treatment to be too expensive and used a mixture of antimony and iodine instead. The government medical officers started to administer intramuscular yaws injections in 1925. Good 2004, pp. 387-388. Follitt, F.D.,"Some notes on the treatment of yaws in Nyasaland", appendix in *Nyasaland. Annual Medical Report on the Health and Sanitary Condition of the Nyasaland Protectorate for the year ended 31st December, 1925.*

134 Oral testimony, S.M., 11 July 2004.

135 *Annual Report for 1901,* pp. 18-22.

136 Laws 20 June 1906. NLS, Acc. 7548 D 71, Letters to the Sub-Committee 1906, pp. 98-99; Chisholm 9 August 1907. NLS, Acc. 7548 D 71, Letters to the Sub-Committee 1907, pp. 93-95. Such long-distance emergency calls usually involved acute European cases.

at Kasungu and cited it as an example of what might be achieved if two surgeons could work together and concentrate on their professional duties. Realistically, he admitted that this would only be possible through considerable external funding and the use of volunteers.[137] Where there was no motor transport, doctors and nurses continued to travel by foot, bicycle or in hammocks/machilas or "bush cars" carried or pulled by Africans.[138]

While during the inter-war period doctors concentrated more on hospital practice, nurses as well as non-medical missionaries and missionary wives undertook tours and minor medical practice during itineration. Mamie Martin, a non-medical missionary wife, prescribed rhubarb pills, cough pills and "grey powders for babies", as well as handing out bandages, boracic powder and ointment for "ulcers and sores" during her *ulendo* (journey) in August 1922. The medicines had been prepared beforehand for her by Nurse Patrick. Medicines provided from the dispensary for tours during 1928 included bandages, lint, lysol, zinc ointment, iodine, "Purgative Pills", cough pills, liniment and quinine powder. Lay missionaries were also dispensing aspirin by the 1920s.[139] African women who were taught nursing and hygiene at the mission would accompany the white nurses on village tours, which lessened the fear and suspicion felt towards the whites in the rural areas.[140]

Outpatient attendances 1895-1929

The recorded statistics of mission outpatient attendances are a problematic source for assessing the actual number of people attending mission medical centres, as noted above. Apart from the often nebulous figures, the official reports were sometimes clearly not up-to-date. For example, in the early 1920s, The Overtoun Institution hospital reported exactly the same annual figures of inpatients, outpatients, and operations during 1919 and 1920, and for the three years 1921–23. Nevertheless, the attendance figures give some indication of the extent of medical practice in Livingstonia.

TABLE 2 Outpatient attendances, all Livingstonia stations, 1895–1929[141]

1895	1902	1909	1914	1921	1929
21,792	35,834	41,000	50,000	44,270	94,000

137 *Annual Report for 1913*, pp. 23-25. Cars were introduced to Livingstonia in the 1920s. In 1924, Dr Wilson had a car in Chitambo. Moffat to Laws 18 May 1924. MNA 47/LIM/1/1/35.

138 A machila was essentially a hammock slung between two poles, while a bush car had a chair where the passenger was seated, and a single wheel with two carrying poles for the bearers in front and two behind. Sinclair 2002, footnotes 15 and 16.

139 "Medicines for Ulendo" 30 May 1928, MNA 47/LIM/1/5/5: Martin 14 August 1922. Sinclair 2002, p. 89; AUL Special Collections, MS. 3289, Caseby Papers, No 21.

140 Oral testimony, L.H.T., 6 July 2004.

141 Compiled from *Half-yearly Report of Livingstonia Mission Jan-June 1895, Half-yearly Report of Livingstonia Mission, July-Dec. 1895, Annual Reports for 1909, 1914, Report on Foreign Missions, 1921, 1929.*

Assessing the actual number of individuals treated using the attendance figures is problematic, but it appears that the patient to attendances ratio decreased with time, as more patients were treated repeatedly, notably for ulcers and skin diseases that required repeated treatment. A rough estimate would be that in the late 1920s, not more than twenty thousand individuals sought medical aid from the missionaries in all Livingstonia stations per year. As the population of the mission sphere of work was estimated to be four hundred thousand (probably too low an estimate) in 1927,[142] the medical mission in Livingstonia provided medical services to not more than five per cent of population in the whole region, at best. However, for the communities near the hospitals and dispensaries, and particularly for the Christian communities, mission medicine was becoming an increasing accepted therapeutic alternative during the first decades of the twentieth century.

TABLE 3 Outpatient attendances, Institution Hospital, 1900-1928[143]

1900	1902	1906	1910	1913	1919	1921	1924	1926	1928
5,703	11,886	17,791	9,021	7914	4,929	11,829	15,810	26,390	13,799

By the early twentieth century, the treatment of fifteen patients a day, which had been an exceptional figure at Bandawe in the 1880s, had become the average for some stations. In 1902, Chisholm reported that the average daily attendance of patients in Mwenzo had been around fifteen, much the same as the figures from the previous year. Mwenzo recorded 5,000 attendances during the year and was the third largest practice in the mission after the Institution and Bandawe.[144] In 1923, when there was a new influenza epidemic during the cold season, the daily attendances at the DGMH, which by now had three medical assistants, a nurse and a doctor, fluctuated between thirty-five and more than one hundred.[145]

The employment of medical assistants and nurses enabled the mission hospitals and dispensaries to receive and treat people more quickly and in greater numbers. In January 1907, after Dr Robertson had just arrived at Bandawe, he reported that between sixty and seventy dispensary patients were seen daily on average. At this time, the assistant Stefano Kaunda had been working in the dispensary for eight years. It was typical that the number of patients peaked during the rainy season (December, January and February), which was often a period of seasonal hunger in the region.[146]

In 1902, then Institution had the largest medical practice, with 11,826 outpatient attendances, of which 4,098 were seen for the first time. The second

142 *Report on Foreign Missions for 1927*, p. 15.
143 Annual Reports, 1900-1914; Report on Foreign Missions, 1918-1926.
144 Annual Report for 1902, p. 58.
145 *Report on Foreign Missions for 1923,* pp. 96-103.
146 Robertson 2 January 1907. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1907, pp. 19-20; Good 2004, pp. 229-230, 254-259.

largest practice was in Bandawe (7,717 attendances), followed by Mwenzo (5,000), Hora (3,663), Ekwendeni (2,917), Kasungu (2,668), and Karonga (1,983).[147] At the Institution, the annual number of cases treated peaked in 1906, with 17,791 cases, a record that was not exceeded until the mid-1920s. The establishment of the DGMH did not result in an immediate increase in the number of attendances. On the contrary, the numbers treated between 1910 and 1914 were considerably lower than the figures for 1899–1907.[148] No credible patient statistics were available for the war years, but it is clear that the African practice must have suffered because of the military demands placed upon the mission. In 1918–19 the Institution recorded its lowest attendance figures since 1900.

Furthermore, the introduction of medical fees clearly decreased the number of outpatient attendances for a time. In 1908, a decision was taken to charge a standard threepence per medical visit, but the implementation of policy seems to have varied from station to station. When fees were first introduced at Bandawe, the annual outpatient attendance dropped from 19,000 to 5,700, although in-patient cases and operations actually increased. It should also be noted that at the time, colonial taxes were increasing and Livingstonia had begun to charge school fees.[149] All these developments made missionary medicine a more expensive option for Africans.

In-patients

Rennick's comparative figures of the numbers of in-patients treated by the Blantyre, Likoma and Livingstonia Central Hospitals show that Livingstonia had fewer in-patients during the period 1902-14 than Blantyre, and, for most of the time, fewer than Likoma. The number of annual in-patients fluctuated between one and two hundred. Regardless of its advanced reputation among Europeans, the new DGMH had difficulty attracting in-patients, especially since the need for migrant workers on the plateau had decreased following the hospital's completion.[150] In 1914, the hospital recorded treating one hundred and fourteen in-patients and performing fifty-nine surgical operations. A record number of two hundred and ten in-patients were treated in 1907, when the

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147 *Annual Report for 1902.*

148 *Annual Reports*, 1900-1914; Appendix 2.

149 *The Livingstonia News*, April 1909, pp. 27-30, *Annual Reports for 1907, 1908*; Fields 1985, p. 109; Linden 1974, pp. 78-79; Vail 1983, pp. 254-256.

150 Rennick 2003, p. 338; Laws estimated that during the period 1901-06 the Institution employed between 1,500 and 2,000 African workers during the busiest building season, while in 1910 the "maximum average" was 578, during September. Laws to Resident, Karonga, 4 April 1911. MNA 47/LIM/1/1/13, 267. Good's study of the UMCA medical facilities shows that in terms of the number of inpatients treated, UMCA was for most of the time ahead of Livingstonia between 1907 and 1929. Good 2004, p. 315.

hospital was still only temporary, and it was not until 1921 that the Overtoun Institution reported admitting over three hundred in-patients.[151]

TABLE 4 In-patients at the Institution Hospital, 1907-1927[152]

1907	1910	1913	1919	1921	1924	1927
210	154	130	189	352	490	450

The Mission Council argued, in 1906, that there was no need for any further African in-patient accommodation at the DGMH, where only twenty-three per cent of the ward capacity was used during 1915. The reasons for this, they stated, were the hospital fees, "*other rules relating to regularity, cleanliness, visits of friends etc., & superstitious fear of a house in which people have died*" Furthermore, they argued that:

> should such obstacles be overcome, even to the extent of our being able to use fifty per cent of our present accommodation, we feel that stronger reasons exist for saying that it is waste to add new wards. The...population is largely artificial & sparse: we are far removed from large centres of population: Livingstonia is difficult to access from all sides: and the difference in climatic conditions between the plateau & the Lake Shore are all none the less iremediable [sic.] drawbacks.[153]

In short, the most expensive and advanced hospital of the mission, and the only one which had a full-time specialised doctor on its staff, had been built away from the African population centres and was logistically very difficult for most Africans to reach. It mainly served the "artificial" population who were in Mission service. The requirements for European nurses' and patients' accommodation were prominent in the Mission Council's plans (as discussed in Chapter 10). The home authorities sanctioned the construction of two African wards regardless of the Council's opposition, advising Laws to use the empty wards as stores or dormitories until they were needed.[154] Thus, the infrastructure for more in-patient accommodation was in place, enabling a growth in hospital practice in the 1920s.

In 1921, whilst Dr Wilson was relieving Laws and the medical course had been resumed, both in-patient and outpatient practice were growing rapidly, and there was a marked increase in the numbers treated at the DGMH and across the entire mission over the decade. During 1924, a record number of 490 in-patients were admitted to the DGMH. The increasing numbers were partly

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151 McIntosh 1993, p. 169; Rennick 2003, p. 231; *Annual Report for 1907*; *Report on Foreign Missions*, 1918-1926.

152 *Annual Reports,* 1907-1914; *Reports on Foreign Missions,* 1918-1927.

153 Minutes of the Mission Council 18 October 1916. MNA 47/LIM/3/17. Reaching the Khondowe plateau from the shore was initially so difficult that the Tonga employed as carriers of the first building party in 1894 rebelled and some fled. A pay rise of one third (to three yards of calico) was required to persuade the carriers to continue. The transferral of the industrial department, pupils and plant material in 1895 was a Herculean task, resulting again in mass refusal and departure of workers. Livingstone 1923 [1921], pp. 276-278. The ascent from inland was somewhat easier, and improved roads had been built by 1910s, but carrying a person up to the plateau from any direction still remained a considerable task in the 1920s.

154 Ashcroft to Laws 27 February 1917. NLS, MS. 7683, 4.

the result of improvements in staffing. With the appointment of full-time doctors to the Institution (first Wilson in 1921 followed by Todd in 1923), nurses and the new medical assistants and students, the DGMH became fully operational again after the war: in 1925, the hospital employed two European nurses, and Laws observed that *"There has been more serious surgical work done in the D.G.M. during the past year than has fallen to the lot of all the Govt. medical men in the country."*[155] The increased practice in the mid-1920s also reflected the general health within the region: in 1923 there was a recurrence of the influenza epidemic and in 1925, a famine in Northern Malawi.[156] A further factor to be considered is the role of various refereeing agents who ordered or advised patients to be sent to the hospital. As noted in Chapter 9, not only missionaries, administrators and planters, but also Africans (notably Christians and former mission pupils and employees in particular) were instrumental in sending patients to the DGMH and other Livingstonia hospitals. The sources available do not allow a detailed assessment of different refereeing agents, but it seems probable that all of the above groups become more active in sending patients during the 1920s.

In 1929, when Livingstonia became a Church of Scotland mission, it had six hospitals and dispensaries, with a total of 94,000 recorded outpatient cases across the entire mission sphere. At this time, the Christian community of Livingstonia numbered 59,940. In comparison, Blantyre and Lomweland Mission with a Christian community of 26,732 had three hospitals and dispensaries which recorded nine thousand cases.[157] Although the figures are only estimates, it can be seen that while Blantyre clearly had the larger practice in hospital medicine (as measured by number of in-patients), in 1929 Livingstonia treated ten times the number of outpatient cases seen at Blantyre, even though the Christian community was only twice as large as that in the north. The sheer size of Livingstonia's sphere of operations was vast compared to that of Blantyre, while the latter was a far more important centre of population and colonial economy within the Protectorate.

Even Laws had to admit in 1926 that patients in Blantyre were better able to pay for in-patient treatment than patients at Livingstonia, but he held that more severe cases were treated and more surgical operations were performed in the DGMH than at the Blantyre hospital, which was largely supported by European planters in the Shire Highlands. Laws defended his plans for the DGMH as an advanced teaching hospital, and argued that, in time, the development of the colonial economy in the Northern Malawi region would make this economically viable. Laws believed that the emergence of major plantations, a coal industry and railways in the north would provide the economic growth that would fund his proposed Livingstonia College and its hospital;[158] it was a vision that was not to be realised. In 1932, Dr Todd gave a

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155 Laws to Ashcroft 12 August 1925. NLS, MS. 7888, 106; *Reports on Foreign Missions* for 1918-1929.

156 Good 2004, p. 383; Iliffe 1984, p. 258.

157 *The Record,* October 1929, p. 436.

158 Laws to Ashcroft 23 December 1926. NLS, MS. 7889, 103.

more pessimistic assessment of the probable scope of medical practice possible at the DGMH. He held that the hospital was simply too remote from the major centres of population and too difficult to reach to become an expanding hospital and a centre for medical education. He observed that surgical practice, which peaked in the late 1920s had declined over subsequent years, as the patients from the Karonga area were increasingly visiting the German hospital in the Tanganyika Territory, which was both "nearer and cheaper". With new hospitals being planned in Karonga and Nkata Bay, Todd argued that, there were no justifiable grounds for expansion and that medical work at Livingstonia should largely concentrate upon the village dispensary service in the district rather than on hospital work.[159] Thus, in a sense, the medical mission in Livingstonia had come full circle from dispensary practice and village visitation to centralised hospital medicine and back again.

Operations

The number of surgical operations performed is a useful means of further assessing the scale and scope of medical practice in Livingstonia. Submitting to an operation generally required a greater level of trust from patients and their therapy managers than was demanded in ordinary medical treatment. Surgery usually resulted in a long stay in hospital, which could be valuable from an evangelistic point of view, in a case where the patient was not already a Christian. The idea of a hospital as an evangelistic agency was built on the theory that a long period of hospitalisation gave the medical evangelists – doctors, nurses, assistants – an opportunity to influence the heathen patients in a way that outpatient practice, could not. The ultimate aim was the conversion of the patient and the transformation of cured patients into protagonists for missionary medicine who would spread the word of both the gospel and the hospital to their homes.

TABLE 5 Surgical operations, all Livingstonia stations, 1906-1914[160]

1906	1908	1910	1912	1914
108	252	181	78	107

It is significant that more annual operations were performed between 1907 and 1910 than between 1911 and 1914. An important factor which contributed to this decrease was the practice of Dr Berkeley Robertson at Bandawe between 1907 and 1910, as discussed in Chapter 9. In 1908, 138 of a total of 252 operations were performed at Bandawe, and many of these were cataract operations.

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[159] Todd to Young 15 January 1932. MNA 47/LIM/1/5/5.
[160] *Annual Reports,* 1906-1914.

TABLE 6 Surgical operations, all Livingstonia stations, 1918–28[161]

1918	1919	1921	1924	1926	1927	1928
135	106	170	1795	720	664	1,358

As with the total attendance figures, the immediate post-war figures for surgical operations were low. Throughout the period 1918–28, most operations were performed at the Institution and surgery in the outstations remained relatively rare. There are no reliable figures available in the published mission reports from 1920 or 1922–23. In 1924, however, a record number of operations were reported, with over 1,600 operations performed at the DGMH, under Dr Todd. For the years 1926 and 1927, additional information about "major" and "minor" operations is available. In 1926, 217 major operations were performed, accounting for over thirty per cent of all operations. On a busy day in 1926, six "severe operations" were performed by Todd. In 1927, only sixty-seven major operations were performed, making up a tenth of all operations. Hospital surgery was concentrated in the DGMH, where there were a number of nurses, medical assistants and medical students and one full-time doctor. In 1926, two hospital assistants who had graduated with government-recognised diplomas were employed at the DGMH, in addition to four medical students preparing for their final examinations.[162]

This helps to explain the apparent paradox that during the 1920s, the extent of medical and surgical practice increased in Livingstonia while the number of qualified doctors in service actually decreased. More specialised, professionalized hospital medicine was able to deal with increasing numbers of patients, and the employment of more European and African nurses and assistants made this development possible, together with increased African mobility within Northern Malawi and the active role of missionaries and African Christians as "refereeing agents" for the DGMH. However, this could not compensate for the location and logistical problems of the hospital. In 1932, when faced with a declining surgical practice, Dr Todd believed that ideal number of staff for the DGMH should be one doctor, one European nurse, one highly trained hospital assistant and five or six African nurses or ward maids. More European nurses were not required, Todd believed, because African nurses were increasingly competent and fewer surgical operations were being performed.[163]

Conclusion

Throughout almost the entire period under review, Livingstonia was led by Laws, whose practice and many roles embodied the nineteenth-century Scottish ideal of an ordained medical missionary in Africa. Rennick has questioned why Laws, in his ambitious programmes, did not "identify a clear and distinct role

161 *Report on Foreign Missions,* 1918-1929.
162 Laws to Ashcroft 13 August and 7 September 1926. NLS, MS. 7889, 65, 75.
163 Todd to Young 15 January 1932. MNA 47/LIM/1/5/5.

for organised healthcare within the developing Protectorate", suggesting that the reason may be found in Laws' ambition and vision of the civilizing and commercialising mission in the region extending "beyond immediate concerns about medical provision".[164] Regardless of its many doctors, Livingstonia remained less effective than smaller missions in the extent of its actual medical practice, as measured by numbers of inpatients, well into the 1920s.[165]

To understand the role of medicine at the Livingstonia Mission under Laws, it is necessary to see it as a part of larger concern, "the quest for health", both individual and collective. Medical practice was only one aspect of a wide-ranging programme for Laws and his colleagues. The central concern of the missionaries, doctors and laypeople alike, was to create a healthy Christian society while securing their own health and that of their families. Both curative and preventive ideas and practices were crucial to this programme. If, as Vaughan has argued, medical missionary discourse presented the health problems of African people and societies as something that could be solved through social engineering and the installation of Christian moral values,[166] then the missionary "quest for health" cannot be understood by analysing medical practice and mission hospitals alone. Medical thought and action must be examined as part of more wider-ranging activity, including planning, preaching, teaching and building. The concurrent African search for health and therapy must also be taken into account.

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164 Rennick 2003, pp. 134-135.
165 Ibid., p. 338; Good 2004, p. 315.
166 Vaughan 1991, pp. 55-77.

5 QUESTS FOR MISSIONARY HEALTH, 1875–1900

5.1 From Cape Maclear to Khondowe: the search for healthy mission sites

> …if natives get the idea into their heads that a place is not healthy, it unfits them for life completely as long as they are in it.[1]

In the instructions given to the pioneer Livingstonia party, the importance of the healthiness of the mission site was emphasised. The party was ideally searching for an elevated gravely ridge with a slope for drainage, which was close to a good harbour, and the instructions explicitly stated that no site should be *"to the leeward of any swamp or marshy land"*. Laws' duties as medical officer included keeping a record of the daily temperature, and *"atmospheric changes, the setting in of rains, the kind of daily employment...immediately following on this, a statement of the health of the party."* This was essential in the prevailing medical view of health in the tropics, which stressed the importance of topography, geography and climate.[2]

During the pioneer party's journey to the lake, the missionaries had been in relatively good health. The fact that they had only experienced slight fever until their arrival was regarded as an exceptionally noteworthy event in itself. Laws had used quinine as a prophylaxis, and had administered daily doses to the whole party during their river journey. Lake Nyasa did not appear to be a promising area to the medical officer: all the villages seen on its shores during the first days were near marshes, and settling near these would be "utter folly". Laws concluded that half of the shores would be "malarious".[3]

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1 Walter Elmslie to George Smith 12 July 1900, NLS, Acc. 7548 D 69, Letters to the Livingstonia Sub-Committee, 1898-1900, No. 98.

2 *Livingstonia: The Mission of the Free Church of Scotland to Lake Nyasa*, Edinburgh 1876 (2nd. ed.), pp. 25, 29.

3 Cape Maclear Journal entries for 27 July and 17 October 1875. NLS, MS. 7908; *Livingstonia: The Mission of the Free Church of Scotland to Lake Nyasa*, Edinburgh 1876 (2nd. ed.), p. 16; Laws to Rev. MacFarlane 21 February 1876. NLS, MS. 7876, 37.

The Cape Maclear area at the southern end of the lake had been chosen as a suitable site by E.D. Young above all because it provided an excellent harbour for the mission steamer. Confined by rocky hills, one obvious drawback of the site was its remoteness from the main population centres. Other disadvantages of the site included the poor quality of the soil for cultivation and, from a medical perspective, the unhealthy low altitude. However, the sandy soil at Cape Maclear was regarded as being comparatively healthy. Young believed that the site was healthy, and in his book published in 1877, stressed that health had been the primary factor in his decision: *"To secure a maximum of fresh cool breeze off the Lake stood uppermost in my mind."* The instructions of the party emphasised the importance of the medical officer's observations on health and climate. It seems therefore probable that Laws agreed with Young's choice of site.[4]

Young seems to have subscribed fully to the theory that fever was caused by poison from the earth and from swamps in particular. He stressed the value of the "beautiful air of the Lake" not only as a prophylaxis but also as a positive medicine which could aid recovery from fever. Apart from poisons emanating from the soil, mid-Victorian medical thought was concerned with "contagion", which was not understood as the transmission of disease organisms, but rather as "emanations" escaping from human bodies, either living or dead, in crowded and unventilated conditions. These ideas lingered in the thought of some medical professionals and in popular conceptions of disease long after they had been questioned and discarded by the medical establishment. Ventilation, in particular, remained essential in ideas about healthy tropical housing long after the discovery that mosquitoes transmitted malaria. It should be noted that although Young was not a doctor, he was an experienced traveller within Africa and, at forty, he was senior to Laws in both age and authority.[5]

Laws' initial medical stores consisted of 153 items, including two cases of brandy, two cases of sherry and one of champagne. To combat fever, he had quinine, "rousers", and mustard plasters, which were applied to the neck and the calves. After the river journey, the use of expensive quinine was limited to therapeutic use, as Laws had only twelve to fourteen ounces in the stores. Although initially no complicated cases occurred among the missionaries, the Cape Maclear Journal for 1875–76 shows that usually at least two of the seven European members of the party would be on the sick list for some part of the day. However, the missionaries had agreed to remain silent on the subject of their illnesses in their letters home, in order to protect the reputation of the Livingstonia project. The symptoms recorded most frequently were fever and

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4 Young 1877, p. 68; McCracken 2000, pp. 67-68; Livingstone 1921, pp. 41, 76.

5 Young 1877, p. 132; Curtin 1992, pp. 237-249.Livingstone 1921, pp. 84-85, 101. In 1876, when Laws, in his professional capacity, wrote Young a medical certificate and advised his return to Britain, Young refused, seeing it has his duty to stay on until the second party arrived.

vomiting; on 16 April 1876, for example, Laws suffered from a sharp attack of fever, *"vomiting and shivering till the bed was shaking."*[6]

The mission was strengthened in October 1876 by the arrival of a second party led by Dr James Stewart, who replaced Young. The party included Dr William Black, four Scottish artisans and four Xhosa evangelists from Lovedale. A predominant Victorian theory about African fevers was that Africans, as indigenous people, were much less affected by fevers than Europeans. The selection, by Stewart, of four Xhosa evangelists from the Lovedale Seminary to join the Livingstonia Mission was partly due to his belief that they could withstand the climate of Central Africa better than the Europeans, notwithstanding the fact that they came from a region hundreds of miles southwest of the Zambezi. This theory proved unconvincing during the river journey, when the Xhosa suffered heavily from fever. One of them, Isaac Wauchope, was invalided back home, diagnosed as suffering from temporary insanity.[7] It is not clear if they were provided with expensive quinine as prophylaxis during the journey.

The initial comments of Stewart and Black regarding the healthiness of the station were optimistic:

> The climate around the lake is by no means bad; fever there is of a much milder type than it is in the valleys of lower Shire and Zambesi; a delightful breeze nearly always blows to or from the water, greatly tempering the heat.[8]

Stewart, who had experienced fever during his first journeys on the Zambezi and the Shire between 1861 and 1863, originally held Cape Maclear in high esteem. The perception of the winds as a "delightful breeze", proved to be short-lived, however. Stewart soon acknowledged that there was no immunity from *"our dreaded enemy, the fever."* He paid close attention to housing and food, advocating boarded floors and plentiful supplies of wheaten food and milk to promote health. He also approved of some of the building decisions taken by Laws:

> The houses...are not mere huts. One of them is fifty feet long by twenty-five, built somewhat like an Indian bungalow. It is cool and airy, having four doors and a plentiful supply of windows and a verandah all round. Another is a two-storey house, with a verandah on the upper storey as well. This is the idea of Dr Laws, and bedrooms twelve feet above the ground will no doubt be healthier than those on the driest of floors below.[9]

Fearing malarial emissions from the soil, Laws had ensured that the bedrooms of his house were as high as possible above the ground.[10]

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6 Cape Maclear Journal, NLS, MS. 7908; Gelfand 1964, p. 35; Livingstone 1921, pp. 81-82; McIntosh 1993, p. 29. Laws had just a small "amputation case" of surgical instruments, costing £11. Laws to Rev. Main 3 January 1879. NLS, MS. 7876, 240.

7 Thompson 2000, pp. 34-43; Worboys 1996, p. 193.

8 *FCSMR* March 1877, p. 60.

9 Stewart to Duff 26 October 1876, quoted in *FCSMR* April 1877, p. 91; Stewart 1894, pp. 22-25.

10 Cf. Collingham 2001, pp. 84-85 for similar practices in early nineteenth-century India.

Young believed that the adequate food provisions of the first party were one reason why they had enjoyed relatively good health, but their supplies only lasted for two years. Additional stores were sent, including coffee, sugar and cheddar cheeses. Missionaries planted their first gardens and purchased, with calico, three goats, which provided fresh milk. By March 1877, nevertheless, Stewart was increasingly worried about food supplies at the station, ordering a ton of flour and half a ton of salt beef to combat the perceived *"debility among the force"*. With eleven yards of cloth, missionaries were able to buy potatoes and water melons from the locals.[11]

Dr Black took over the medical department from Laws soon after his arrival. He confirmed that the soil at Cape Maclear was poor but not particularly malarious. Black observed in 1877 that the Europeans at Cape Maclear had been in relatively good health, but that almost everyone had had their share of fever attacks. Black had personally suffered from a dozen attacks so far, some lasting for three or four days, others for just a few hours. However, he asserted, *"None of us seem to dread fever up here on the Lake any more than we would a common cold at home."*[12]

Black was to be the mission's first European casualty. He fell critically ill in May 1877, while Stewart was in Blantyre and Laws was away on the steamer. A year later, Laws provided a detailed description of Black's terminal illness in a letter to Mrs Findlay. On his return to Cape Maclear, Laws found Black very jaundiced and somewhat confused, suffering from a high fever and severe vomiting. He suspected that Black had accidentally taken an overdose of morphine. Laws prescribed calomel (five grains) and jalap (fifteen grains) as purgatives, and administered chloral hydrate (fifteen grains), which the patient vomited. As Black's condition worsened, Laws applied a large mustard plaster to his stomach, which seemed to revive him somewhat. Black was able to speak coherently to Laws about his illness, saying that he wanted to go home but not because he was discouraged by the work. When Black took another turn for the worse, Laws resorted to the use of champagne and more mustard plasters. Ultimately this failed to revive Black and he died after six days of illness. Laws consulted both Dr Macklin of Blantyre and Cotterill, an aspiring trader, about his treatment,[13] demonstrating that pioneer doctors in times of crisis were not above asking the advice of European laymen. In his letter, Laws also had to stress that Black had not lost his faith in the mission.

Two other missionaries died at Cape Maclear in 1877, Shadrach Mngunana from Lovedale and John Mackay of Blantyre. Neither of these deaths was directly linked to malarial fever or the climate, however. Laws stated in his

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11 Stewart to Duff 28 March 1877. NLS, MS. 7876, 194; Young 1877, p. 84; Livingstone 1921, p. 42; McIntosh 1993. In his emphasis on the importance of meat diet in Southern Africa, Stewart was following the beliefs of Livingstone. Cf. Livingstone 1857, p. 117.

12 Black to Smith 3 March 1877. NLS, MS. 7876, 176.

13 Laws to Mrs Findlay 12 March 1878. NLS, MS. 7876,221. The reference to morphine gives grounds to suspect that Black may have taken the drug for depression: morphine was used for this purpose among some Victorian doctors, see Oppenheim 1991, p. 114.

medical report that the general health of the missionaries had actually been better than expected. Nevertheless, he saw the climate as a major obstacle to health, as it *"reduces mental and bodily vigour to a minimum"*. Mental and physical vigour, vitality and energy were essential elements of Laws' theory of health in the tropics, and a feeling of loneliness and lack of communication with the outside world were potentially dangerous. *"The arrival of a large mailbag is in itself an excellent medicine"*, Laws argued. Better communications improved the state of both mind and body, and also brought the highly-valued "English provisions".[14]

Because the missionaries' selection of therapeutic medicines to treat fever and intestinal diseases was limited, preventive hygienic ideas and initiatives became crucial in the pioneer conditions. There appears to have been a feeling among the missionaries that Black's illness and death, in particular, were partly influenced by depression and disillusionment.[15] Young held that "elastic spirits" were essential for European health in Central Africa. At Blantyre, missionaries took to playing cricket with their pupils in the evenings in 1880, a game that was for Rev. Duff Macdonald a *"simple means of securing that amount of physical exercise which is indispensable for preventing a European from becoming a continual martyr to fever."*[16] At Livingstonia, a doctrine of work and useful reading rather than play, became typical form of preventative medicine under both Stewart's and Laws' leadership.

The soil and weather conditions were seen to be crucial in the causation of fever. Digging or disturbing the soil was believed to be dangerous, with malarious exhalations were released from the ground. Illness during the cold season of 1876 was explained by the theory that the cold winds had brought malaria, chills and rheumatism. When the health of the Europeans improved during 1878, Laws suspected that the dryness of the year could have had a positive impact. He also praised the benefits of the visits of Livingstonia missionaries to the higher altitude at Blantyre, where he felt *"the clean bracing air greatly invigorates each individual."*[17] Drs Stewart and Laws, and Stewart's cousin (a civil engineer) enjoyed this benefit from December 1876 to 1878, as they in turn took up the leadership of the Blantyre Mission. Blantyre was on the point of collapse, without an ordained missionary or clearly defined leadership, and was troubled by demoralisation and disease. For Laws, who was suffering from fever and insomnia in December 1879, the removal to the cool uplands "worked magic". As Eric Jennings has noted, for the late nineteenth-century colonialists, the search for health was often a quest for altitude. Travelling itself could be

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14 Medical report for 1876 and 1877. NLS, MS. 7908; McIntosh 1993, p. 47. Missionary doctors attempted to closely follow the developments in medicine: in the 1880s both *the Lancet* and *British Medical Journal* had been ordered for Livingstonia. Scott to Laws 17 March 1887, Cross to Laws 7 April 1887. NLS, MS. 7890, 57, 70.

15 When Waterston asked for a recall from Livingstonia in late 1879, she wrote: *"It is a mercy I am not taking fever as I am so depressed it will fare with me as it did with Black."* Waterston to Stewart 11 December 1879. LJEW, p. 162.

16 MacDonald 1969, p. 225; Young 1877, p. 89.

17 Livingstonia Mission Report for 1878. NLS, MS. 7876, 243; Livingstone 1921, pp. 81-82, 96.

perilous and opinions on the subject varied. Unlike Young, who stressed the importance of speed and staying on the move, Laws' principle was to travel slowly, methodically and "as comfortably as possible to ensure good health."[18]

Laws took on the leadership of Livingstonia after Stewart's departure to Lovedale in December 1877. Stewart, who felt he was too old for the task, had been severely weakened by repeated fever attacks and at one point his sanity had even been called into question by Cotterill. Stewart tended to deny that he was suffering from fever, disregarding all the apparent symptoms.[19] Through his denial, Stewart was apparently trying to "work off" the illness and to stay healthy; to admit fever was to submit to confinement in bed, which was not without its own dangers.

In December 1879, James Stewart (the civil engineer) gave a report of his journey to the northern end of Lake Nyasa and Tanganyika. He judged possible new sites for mission stations according to the criteria of suitable temperature: sites were judged to be healthy if they were cool, unhealthy if hot. However, the cool areas could also be hazardous to health, especially for the African members of Stewart's party, who suffered from *"Fever, dysentery, pneumonia, and jaundice"*.[20] One of Stewart's men died, and he was criticised by Jane Waterston for not paying sufficient attention to his own men. Dr Waterston reported that it was the Xhosa evangelist William Koyi who saved many of the Tanganyika party. Furthermore, upon their return, neither the engineer nor Laws examined or treated the Tanganyika men. Koyi took the patients, including one man who was "very bad with dysentery", to Waterston, who treated them quietly.[21] In this case, the Europeans' quest for high ground and cool temperatures was followed by reports of their African companions, carriers, and subordinates suffering from colds, coughs and other illnesses associated with cold conditions.

By October 1881, the Livingstonia missionaries were ready to move their base of operations to Bandawe in uTonga, which had been proposed as a site for some years, and where the mission had had an observatory post since 1878. Laws had initially opposed the move suggested by Stewart, but by 1880 had accepted come to accept it. Although political problems and difficulties in the evangelistic sphere were crucial factors which influenced the decision to move to Bandawe, issues of health were also important to the missionaries. Of the seventeen Europeans and three Xhosa evangelists working in Cape Maclear between 1875 and 1880, four had died. Two of the deaths were attributed to

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18 Black to Smith 3 March 1877. NLS, MS. 7876, 176; Jennings 2002, p. 245; Livingstone 1921, pp. 105, 131, 146; McCracken 2000, p. 84. Macklin, the doctor of the first party, had been confined to bed for a month.

19 Livingstone 1921, pp. 114-115; McCracken 2000, pp. 68-69.

20 "Report on Journey of Exploration, September to December 1879", p. 6, in *Livingstonia Mission Report,* September–December 1879. In his journal, Stewart wrote that the Yao, who had "parted with their warm clothing", suffered the most in his thirty-strong expedition. The men suffered mostly from dysentery and "sore bones", and Stewart prescribed calomel and "blue pill" for the worst cases. Thompson (ed.) 1989, p. 91.

21 Waterston to Stewart 29 December 1879. LJEW, pp. 162-163.

malarial fever, one to “malarial dysentery” and the Xhosa evangelist Shadrach Ngunana had, according to Laws, died from consumption.[22] In the concept of “Malarial dysentery” malaria was understood not as a specific febrile disease, but as poisonous air predisposing to or directly causing disease.[23] Thus, “malarial dysentery” was dysentery connected to air poisoned either by miasma or zymotic substances.[24]

In August 1877 the initial appeal for a change of site stated that Cape Maclear was, *“from a variety of causes, quite unsuitable”*. Health reasons were not explicitly mentioned, but the poor soil and isolated location were emphasised. Laws, who at the time opposed the move, may have countered other missionaries’ arguments regarding health at the Cape. As the medical officer, he (along with Young) was responsible for the original choice of the site. After the deaths of 1877, there were doubts in Scotland about the healthiness of the Cape site. Laws however refuted the idea that Cape Maclear was particularly unhealthy, but argued that the prevalence of tsetse was its main drawback.[25]

Three years later, Stewart wrote from Lovedale to the home authorities, giving testimony about the problems of Cape Maclear. Stewart now stressed malaria as one of the main reasons for supporting the withdrawal of European missionaries from the station, and came to the opposite conclusion to that of Laws about the soil surrounding the station: *“…the immediate site of the buildings is a sandy soil – one of the worst for malaria.”*[26] Jane Waterston had written to Stewart about health problems at the station in February 1880, but it was not the soil itself, rather the poor drainage and sanitation that she feared. Laws remained careful in his statements about the healthiness of the new site at Bandawe, and in early 1881, his “qualified praise” of Bandawe had prompted some doubts among Committee members about the wisdom of the move.[27] During this time the relationships between Livingstonia and Blantyre, in the aftermath of the “Blantyre Scandal” of the early 1880s, were strained. Dr Rankin (a doctor of theology) of the established Church was reputedly “blackgaurding” the Livingstonia authorities and was claiming that Livingstonia recruits were going out “under sentence of death” because of malarious miasma at Cape

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22 Medical Report for 1876 and 1877. NLS, MS. 7908; Livingstonia mission report for 1880. NLS, MS. 7904; *Report on Foreign Missions for 1889*, p. 18; McCracken 2000, p. 85. In addition, one missionary died on his way on Zambezi.

23 Worboys 1996, pp. 183-186, 201.

24 Waterston held that Captain Benzie of the mission steamer Ilala had died of “malarious dysentery with complications” which included *“general poisoning of the system and a sinking from exhaustion therefrom.”* Waterston to Stewart 14 February 1880. LJEW, pp. 166-167. Benzie and John Gunn the agriculturalist died in 1880. McIntosh 1993, p. 69. It is difficult to say whether the “general poisoning of the system” was here regarded as miasmatic or zymotic in origin.

25 Livingstonia Missionaries to the Foreign Missions Committee 6 August 1877. NLS, MS. 7876, 214; Livingstone 1921, p. 116.

26 Stewart to the Secretary of the Livingstonia Committee 18 August 1880. NLS, MS. 7876, 304.

27 Waterston to Stewart 14 February 1880. LJEW, p. 168; Stewart CE to Laws 7 April 1881. NLS, Acc. 9220 (i), (i).

Maclear and elsewhere on the shores of the lake.[28] In response to Stewart's criticism of Bandawe, the Convener of the Livingstonia Committee stressed the need to continue exploration of the western side of the lake in search of a "European climate". Meanwhile, frequent removals to higher ground were required in order to secure European health.[29]

After the move to Bandawe, the supposedly healthier location of the new site was emphasised in the published mission report,[30] although in private the controversy continued. Medical arguments in favour of moving a station could be a politically effective means of gaining permission and acceptance from home authorities: for, who in Scotland could argue with the medical officers of the mission who were on the spot? Cape Maclear was left in the hands of the first African convert of the mission, Albert Namalambe. In this way, African agents gained more independent space within the miniscule Christian community, as an indirect result of the missionaries' quest for health.

"The fever", acclimatisation and "the system"

James Stewart believed that "the fever" was the only real obstacle to European colonisation of Central Africa. In this belief, he echoed Livingstone who had, in the early 1860s, deliberately played down the significance of fever in order to promote European settlement in Africa. At a meeting of the Royal Geographical Society in 1879, Stewart's emphasis upon fever was challenged by a Mr Hutchinson, who argued, on the basis of the reports of the pioneer Church Missionary Society party in Uganda, that it seemed all of the European deaths seemed to have been the result of dysentery, rather than fever. Stewart retorted that in reality dysentery was always accompanied by some kind of fever, and that *"the chief action of malarious fever was to poison the nervous centres, to affect the digestive and assimilative powers, to lessen the vitality, to destroy the power of the man, and to reduce him to utter weakness."*[31] Nerves, digestion, "assimilative powers", vitality and manly strength were all damaged and diminished by fever and protecting them was, for Stewart, vital to health in Africa.

During this period of extremely high European mortality in Central Africa, for some it seemed questionable whether it was possible for Europeans to live there at all. In the 1880s, "the fever" remained mysterious and was much debated among European travellers and medical authorities. Henry Drummond synthesised the prevailing ideas in Central Africa in the mid-1880s, after his

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28 Johnston to Smith 8 January 1882. NLS, MS. 7872. In retrospect, W.P. Livingstone, Laws' biographer, argued that apart from the nearby marsh and standing water, the Cape Maclear station would have been, in fact, ideal. He criticised Stewart's assessment and defended Laws' decisions as a medical officer. This has to be seen in the context of the early 1920s, when the much-criticised Bandawe station was finally moved to a new location a few miles inland. Livingstone 1921, pp. 86, 101.

29 "Memorandum by Convener in regard to Dr Stewart's Letter of 18th August 1880, addressed to the Secretary of the Livingstonia Mission Committee". NLS, MS. 7904.

30 *Report on Foreign Missions for 1881,* p. 58.

31 *Proceedings of the Royal Geographical Society, May 1879*, pp. 321-324.

visit to Livingstonia. The "geography of fever" he argued, was still unmapped: it seemed to prevail on coasts, rivers, lakeshores and in low-lying and marshy regions. Higher plateaux, by contrast, seemed to be comparably free from fever. However, it was believed that when travelling through malarious areas, the *"system becomes saturated with fever, which often develops long after the infected region is left behind."* [32] In a holistic theory of disease, "the system" of the individual was attacked and weakened by the fever poison and other adverse elements in the climate. When pioneer missionaries felt that they needed a change of climate, they frequently mentioned that their "systems" required it.[33] According to Drummond the "known facts" about African fever were firstly, that it was somehow connected to drying-up water and decaying vegetation, although the exact nature and development of malarial "germs" was unknown. Secondly, Africans suffered from fever comparably with Europeans, and especially when on the move and when changing altitude. Thirdly, quinine was *"the great and almost sole remedy"*. Finally, no European could ever entirely escape fever. Drummond, while praising the work of missions in Central Africa came to the conclusion that fever was *"plainly a barrier of Nature"*, and that science taught that *"no devotion or enthusiasm can give any man a charmed life"*.[34]

Laws, who met Drummond at Bandawe, was one of the medical authorities with whom Drummond held his discussions. Laws, however, fundamentally disagreed with Drummond on the question of European acclimatisation in Central Africa. The underlying assumption of the Livingstonia Mission project was that it was possible, although dangerous, for Europeans to live and work in Africa. The duty of the missionary doctors was to minimise risks to health by providing therapy, but above all by maintaining health at the mission stations and on journeys. Careful living was the watchword for survival, and regularity and routine were crucial to the maintenance of health.[35]

The vital internal organs for the human "system" and survival in the tropics were the liver, spleen, kidneys and digestive system. In serious cases of fever, doctors noticed that the spleen and liver in particular become affected, and protecting these organs was crucial. Bilious discharge was a symptom of many illnesses, and "biliousness" or "bilious fever" was a common diagnosis in the 1880s, as was "jaundice". In these instances, symptoms and disease were

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32 Drummond 1888, pp. 42-45.

33 See, for example, Simpson to Laws 16 September 1879. NLS, Acc. 9220, (i), (i).

34 Drummond 1888, pp. 42-45. Other travellers in the 1880s also visited the deserted Cape Maclear, which they called Livingstonia (as it was referred to on the maps), after the missionaries had moved to Bandawe, and presented a critical picture of a mission abandoned after sickness and death, and questioned the entire enterprise. Stewart 1894, pp. 103-116. It is particularly noteworthy that Drummond, whose most experienced medical authority in the area was Laws, clearly stated that Africans suffered from fever and particularly when moving from area to area. As Curtin notes, until the late 1890s colonial medical authorities generally believed that Africans had innate protection against malaria. Curtin 1992, p. 238.

35 When Elmslie suffered from high fever in Bandawe in late 1885, he astonished his colleagues by having regular meals and his daily pipe. Elmslie to Laws 23 December 1885. NLS, Acc. 9220 (1) (iii). Cf. Fabian 2000, pp. 58-60.

often confused. In the tradition of humoral pathology, which continued to influence doctors' and laymen's conceptions of health and disease at least until the turn of the century, every part of the body was related to all other parts, and the indisposition of one could affect the others.[36]

For Dr Walter Elmslie, the liver was a crucial organ for the survival of the pioneer. In October 1885, he wrote to Laws that the artisan missionary McCallum had recovered in Ngoniland from a very severe attack of fever and "liver". The patient had been acutely jaundiced and Elmslie had feared for his life. Elmslie argued:

> I am laughed at for being a theorist but my theory is that since "liver" has been present in all the fatal cases almost we ought to be very careful as to the work we give it to do, because it will not bear the strain which it could do at home.[37]

Elmslie particularly criticised those missionaries who drank cow's milk in Ngoniland, believing that the practice would lead to *"congestion of the liver & bile"*. He had seen "*the grossest carelessness in eating & drinking...*" such as *"a man vomiting bile & purging in the morning devour a plentiful of bananas and milk in his bed in tea time."* Elmslie felt that some missionaries had been *"too stout for Africa"*, and asserted that he himself was healthy partly because he was thin. Vigilance and moderation in eating and drinking were essential. The importance of protecting the liver also strengthened medical arguments in favour of total abstinence in the tropics.[38]

For the pioneer generation of missionaries, the prevailing weather conditions were connected to health.[39] E.D. Young had believed that the unhealthiest period in the area was during April and May, because of rapid evaporation after the end of the rains, and particularly because of the sharp fall in night temperatures. The rainy season and its aftermath were generally held to be the most dangerous periods of the year.[40] The "chill theory" of fevers, which was widely subscribed to during the 1870s and 1880s, suggested, in Worboys' words, "that it was not extremes of heat and humidity that were important, but the degree of variation and rates of change on the individual's physiology."[41] After a patient whose kidneys had been damaged died in uNgoni in 1887, Elmslie sent kidney specimens to Laws, who had recently

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36 Sutherland to Laws February 1884, n.d.; Munro to Laws 12 September 1883, NLS, Acc. 9220, (1) (ii); Curtin 1992, p. 238. In December 1884, James Sutherland, a mission agriculturalist at the Ngoniland station, wrote to Laws that he had been healthy for almost six months, emphasising that "*My spleen has kept its place since I left the lake and also my liver has done its duty...today I am as strong as...three years agone.*". Sutherland to Laws 23 December 1884. NLS, Acc. 9220 (1), (ii). See also Bain to Laws 30 May 1885. NLS, Acc. 9220 (1) (iii).

37 Elmslie to Laws 12 October 1885. NLS, Acc. 9220 (1) (iii).

38 Ibid.; Elmslie to Laws 23 December 1885. NLS, Acc. 9220 (1) (iii).

39 See, for example, Elmslie to Laws 27 January 1887. NLS, MS. 7890, 15.

40 Young 1877, p. 153; Cross to Laws 4 July 1885. NLS, Acc. 9220 (1) (iii). In December 1876, upon arriving at the Mozambique coast for the first time, Stewart CE believed that "Fever cannot be bad at the commencement of rains". Stewart also believed that rain and dew were especially dangerous. Thompson (ed.) 1989, pp. 20, 29.

41 Worboys 1996, p. 187.

obtained the first microscope in the country. Elmslie was certain that *"The alternate heating and cooling through his hunting had probably established something which predisposed to the fatal issue through kidney mischief."* Protection from exposure through the use of appropriate clothing, and in particular the wearing of tropical helmets, became standard disease prevention procedures in the tropics.[42]

The lakeside and hill stations

At Bandawe, Laws was more concerned about the air and the winds than the soil. The new station was built along the top of a sandy ridge, one hundred and seven feet above the lake, and Laws designed the new station so that the houses faced inland, thus avoiding the miasmata blown up from the water.[43] The initial assessment of the healthiness of the lake winds at the Cape was completely reversed. For European missionaries, the air at Cape Maclear became associated with sickness and death: in 1884, the newly arrived Dr William Scott felt the "oppressive air" there.[44] In 1887, Laws observed that the Africans had made the station at Bandawe less healthy by "cutting down a breakwind of trees between us and the north". Laws and Thomas Binnie of the Livingstonia Committee proposed the planting of fast-growing eucalyptus trees to shelter the station from "harmful winds". The use of mosquito "curtains" was enforced, particularly during "bad winds".[45]

In an unpublished memoir describing his first years at the Bandawe station in the early 1890s, A.G. MacAlpine recalled how Elmslie tested the nerves of the new recruits after sundown during a south-east wind by saying *"That's the wind that blows poor missionaries to their graves!"*. MacAlpine added, *"The remark was, of course, to be taken 'cum grans' (though we didn't realise at the time) and it served for long as a grim 'N.B.' of warning to beware of the monsoon."*[46] In

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42 Elmslie to Laws 25 February 1887. NLS, MS. 7890, 33; In 1920, W.P. Livingstone described Laws' standard clothing: khaki jacket and trousers, and an "enormous boat-shaped helmet". In Bandawe in the early twenties, helmets were worn more often than hats, which were used only in the evening or early morning; but in the Institution, hats were more frequently worn. Martin 23 October 1922. Sinclair 2002, p. 95; Livingstone 1921, p. 362; Cf. Fabian 2000, p. 59.

43 Gelfand 1964, p. 233; Livingstone 1921, p. 185. In 1921, a recently arrived missionary wife, Mamie Martin noted with disapproval how the old house at Bandawe, faced inland with no view of the lake whatsoever. M. Martin 26 November 1921. Sinclair 2002, p. 23.

44 Scott, quoted in *FCSMR*, February, 1885, p. 50.

45 Laws, quoted in *FCSMR,* March 1887; Binnie to Laws February 1891 (n.d.). NLS, MS. 7899. Eucalyptus trees were believed to clear the air from malarial miasmata, and had been widely used in Italy. In Scotland, the idea of taking Eucalyptus to the African mission fields for this purpose was put forward by J.C. Brown, who published a pamphlet on the subject in Aberdeen in 1890. Brown 1890, in CSCNWW, *Nyasaland and Kikuyu, Vol. II,* 120. Eucalyptus was also planted around Laws' Stone House at the Institution. Livingstone 1921, p. 360.

46 "Biographical account of life & work in Bandawe, 1893-94", n.d., p. 3. EUL, MacAlpine Papers, MS. 3086. 4. MacAlpine mentioned that he wrote this typescript "more than 58 years later", in early 1950s.

his memoir written during the early 1950s, MacAlpine, with hindsight, stresses that Elmslie's warning was not to be taken literally. However, in the early 1890s winds were taken very seriously not only by new recruits, but also by experienced missionary doctors.[47]

The editor of the Livingstonia magazine, *The Aurora,* noted that in 1897 during a spate of grass fires, there had been an increase in the number of fever cases among both Africans and Europeans. *"Is it due to the burning of grass in distant swamps and the imperfect destruction of malarial germs by fire, and their subsequent distribution by local winds…"*[48], asked the writer, linking the old association between swamps and malaria to the transmission of "malarial germs" by local winds, as something floating in the air. By the late 1890s, the germ theory of disease was becoming predominant within medical circles, and as Worboys has shown, various ideas about malaria at this time were very much part of the wider, colourful discussion about germs.[49]

Hill stations remained health resorts for the missionaries. When the move to Bandawe was planned, the need for a specific "sanitarium" was stressed by the mission authorities. The extension to uNgoni was a logical step from Bandawe to higher altitudes. When the Ngoniland station was established in April 1882, it was regarded as a sanatorium.[50] In June 1885, Sutherland reported to Laws that he had had no fever "worth mentioning" for over a year while in Ngoniland, a fact he attributed to the climate. In late August, Sutherland moved to Bandawe: within a month, he was dead. Following the deaths of Sutherland and the recently arrived George Rollo in late 1885, John Stephen of the Livingstonia Committee (who was also one of the directors of the ALC) wrote to Laws insisting that whenever possible, the missionaries should work on "healthy hill stations" and work at the lower stations only with "frequent changes of men". New recruits in particular should be based at the hill stations until "seasoned".[51] Elmslie even felt guilty about working at a supposedly healthy hill station. In early 1890, Laws and Elmslie swapped sites while the

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47 When Mrs Elmslie suffered from "severe remittent fever" in 1892, Elmslie wrote to Laws *"The very cold winds from S. did it all."* Elmslie to Laws 11 August 1892. NLS, MS. 7896, 109. As late as in 1900, Elmslie explained the illnesses suffered by Africans at the Institution as resulting from *"the long rainy season, extreme cold with fogs and east wind". Livingstonia Mission Report for 1899-1900,* p. 4.

48 *The Aurora* October 1897, p. 34. The anonymous editor during this period was Laws, except when on furlough. Bush fires and malaria were connected in a new way in the 1920s, when it was believed that the fires caused mosquitoes to invade villages aggressively. See AUL, MS. 3289, Caseby Papers, No. 24.

49 Worboys 1996, pp. 192-194. Before it was established that mosquitoes were carriers of malaria, the discussion about malaria transmission was very varied. Worboys argues that during the 1890s there was a general move from "free-floating" germs, supposedly in the air or "everywhere", preferred by Lister and the general British medical establishment, towards ideas of fixed exchange mechanisms, put forth especially by German medical authorities.

50 Minute-Book of the Sub-Committee of the Livingstonia Mission, Minutes of meeting 5 April 1880 and 4 April 1881. NLS, MS. 7912; *FCSMR* September 1882, p. 269. In 1884 James Sutherland argued that *"If my good health is any criteria...Angoniland has not its equal."* Sutherland to Laws 23 December 1884. NLS, Acc. 9220, (1), (ii).

51 Sutherland to Laws 17 June 1885. NLS, Acc. 9220 (1) (iii); Stephen to Laws 2 April 1886. NLS, Acc. 9220 (3) (v).

seriously ill Laws going to Ngoniland to recover his health. The doctors agreed that unless Laws recovered remarkably quickly, a period of six weeks to two months should be spent in the hills.[52]

Missionary work at Bandawe continued until the 1920s, although from time to time criticisms were made about the healthiness of the station. Following the death of Rev. Bain in 1889, Laws defended Bandawe and, quoting Archdeacon Johnson of the UMCA as an authority on the lake region, stated that Bandawe was "the healthiest spot on its shores". On this occasion, Laws did not hesitate to provide medical evidence from his non-medical friend whose personal lifestyle he held to be exceedingly unhealthy. As a final line of defence, Laws stated that as Christ had chosen to work in the "unhealthy malaria-stricken Capernaum", missionaries should follow suit.[53] His medical arguments had obviously been weakened by this point.

The issue was especially controversial in the early 1890s. Some missionaries referred to the guest room at the Bandawe station as the "death room". Elmslie and Laws defended Bandawe ferociously, but privately Elmslie wrote to Laws that there was no denying that the soil underneath Bandawe was swampy. J. Fairly Daly, the secretary of the Committee, sympathised with Laws over the difficulty of selecting suitable sites, but emphasised that *"the health of our European agents we consider to be of the first importance"* and suggested in 1891 that all the shore stations should be manned by Africans, as had been the case at Cape Maclear.[54] In 1892, Dr David Fotheringham, stationed at Bandawe, suggested that moving the station a few miles inland would improve the health of the mission staff greatly, estimating that the fever took up a quarter of his working time, *"in spite of all reasonable precautions such as carrying umbrellas, protecting the head with helmets etc."*[55]

Laws employed statistics in his defence of Bandawe. In January 1893, Thomson, the printer at Bandawe, sent Laws (who was on furlough in Scotland) a list of "European" and "Native sick time" at the Printing Office, showing that during 1891, Thomson had recorded only thirteen hours of European sick time. In 1892, the total European sick time was twenty-seven hours, and since June there had been "*little or nothing of fever.*"[56] It seems Laws requested this evidence from Thomson in order to prove that Bandawe was healthy enough, to counter the evidence of Fotheringham and others. Thomson was the only European worker in the printing department and so this was highly selective evidence. However, the recording of sick time to within half hour accuracy is a curious example of time keeping in the industrial Livingstonia. In such an endeavour Presbyterian work ethics combined with the scientific desire to measure and

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52 Elmslie to Laws 26 February 1887. NLS, MS. 7890, 37; Elmslie to Laws 15 March 1890. NLS, MS. 7893, 31.

53 Livingstone 1921, pp. 248.

54 A.G. MacAlpine, "Biographical account of life & work in Bandawe, 1893-94", p. 3. EUL, MS. 3086; Elmslie to Laws 27 June 1892. NLS, MS. 7896, 91; Daly to Laws 2 July 1891. NLS, MS. 7899, 41.

55 Fotheringham to Laws 24 September 1892. NLS, MS. 7896, 121. Fotheringham did not mention quinine at all.

56 Thomson to Laws 24 January 1893. NLS, MS. 7896, 167.

record health, and the influence of illness on work efficacy. If Fotheringham had been "proved" correct, and the real European working time at Bandawe had been measured as seventy-five per cent of the "normal" at most, the case for European departure from Bandawe would probably have been made.

By 1893, then, different departments apparently recorded the health of "European" and "Native" people on mission stations separately. In any case, the order of precedence in the preventive, public health schemes had been made clear. The reputation of the mission and consequently its support and existence, depended upon the care it took of its European agents, who could cause considerable damage through complaints at home. African agents had no such voice. Among the lakeshore stations, Bandawe remained under European supervision, Cape Maclear was entirely run by African agents and Karonga was for some time under African control. In 1901, the construction of a hill sanatorium near Bandawe was sanctioned. Finally, in 1922 Bandawe station was moved to the site of the former sanatorium, a cooler location four miles inland.[57]

The Livlezi Valley station, situated among the Chewa people, belonging to the sphere of influence of the southern Ngoni, was abandoned entirely due to illness. Mission teacher McIntyre died at Livlezi station in 1890, Mrs Henry died in May 1892, and Dr Henry and his nephew, James Aitken, died the following year. The loss of this station checked the advance of Livingstonia southwards. Livlezi was given over to the Dutch Reformed Church in 1895.[58] The history of the mission stations at the north end of the lake was also marked by illness and death. Initially, Bain had settled in Mweniwanda's village fifty miles from the lake. Dr Cross, who accompanied Bain there in late 1886, believed that the place was a "health spot." Within a few months of their arrival, Mrs Cross and the carpenter Macintosh were dead and the seriously ill Dr Cross had to move to the ALC station at Karonga to recover. Initially, Bain and Cross blamed the half-constructed house, with its damp walls and cold draughts, where the Crosses had settled for their illness.[59]Another station abandoned because of European health concerns was Kazembe's in the Loangwa valley, following the illness and death of Mrs Boxer in 1905. Dr Boxer was convinced that the site was not to blame, but Elmslie did not hesitate to condemn Kazembe's as a permanent European residence. In this respect, Elmslie drew heavily on the opinion of MacAlpine. In an assessment of the healthiness of localities in Africa, senior laymen in the field could have comparable authority to junior doctors.[60]

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57 Daly to Laws 26 September 1901. NLS, MS. 7864, 49; Martin 26 September 1921. Sinclair 2002, p. 14. The change was in 1921 justified by cooler temperature. The average temperature at Old Bandawe during hot season was thirty degrees Celsius, occasionally over thirty-four degrees.

58 McCracken 2000, p. 136. Quotes *FCSMR* May 1888, pp. 134-136 and January 1888, pp. 12-13; Elmslie to Laws 15 March 1890, NLS 7893; *Report on Foreign Missions for 1892* and *1893*; McIntosh 1993, p. 108.

59 Cross to Laws 7 August and 26 December 1886, Bain to Laws 26 December 1886. NLS, Acc. 9220 (1) (iv).

60 Elmslie 4 December 1905. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1906, pp. 26-27.

By 1892, Laws had become convinced that the most important expansion of the Livingstonia Mission should be an educational centre for African teachers, evangelists and craftsmen. In 1894, he selected a site for the new Institution in Khondowe on high ground, between the Nyika plateau and the lake. Laws succeeded in securing a vast area of land from Cecil Rhodes' British South African Company, and building began in 1895. Laws' selection of a remote site may have been, in part, due to his desire to keep the mission some distance away from the white settler community, but medical arguments were also crucial in the choice of location. A small hospital was included in the initial plans for a central hill station that would provide a sanatorium for all Livingstonia staff.[61]

The selection of Khondowe and the urgency of the move, criticised by almost all of Laws' colleagues, have to be seen in the wider context of the bitter arguments over the healthiness of mission stations and the concerns of European missionaries in the late 1880s and early 1890s. Although Bandawe was not abandoned by European agents, the mission headquarters moved to an altitude of three thousand feet above the lake. Up on the plateau, Laws and his wife experienced, in the words of W.P. Livingstone, "vigour and energy to which they were strangers at Bandawe". By 1898 the Institution, which was still under construction, had already established a reputation as a European sanatorium: eleven non-mission European patients were treated there during the course of the year. UMCA missionaries from the other side of the lake were especially grateful for the time they spent recuperating at Khondowe.[62]

5.2 Experiencing illness

Henry Drummond described an attack of malaria in 1883: *"first cold and pain, then heat and pain, then every kind of pain, and every degree of heat, then delirium, then the life-death struggle.* [the sufferer] *rises, if he does rise, a shadow..."*[63] When they were able to do so, European patients and physicians measured and timed their fever episodes and recorded temperature, pulse rates, and frequency of attacks. Allan Simpson reported from the Bandawe observatory post to Stewart CE that *"I have had six attacks of fever since you left taking it every 48 hours."*[64]

In Cape Maclear, the rainy season of 1879–80 was regarded as having been unusually unhealthy. Dr and Mrs Laws and others suffered, in Livingstone's words "from a low tedious fever which enfeebled the body and wore out the

61 Laws, "Memorandum regarding the Organisation and Development of the Livingstonia Mission", printed in *The Livingstonia Mission, 1875-1900*; Livingstone 1921, p. 258; McCracken 2000, pp. 171-172.

62 Eyre to Smith 28 September 1898. NLS, MS. 7874, 54; *Report for Foreign Missions for 1898,* pp. 103-104; Livingstone 1921, p. 276.

63 Drummond 1888, pp. 42-45.

64 Simpson to Stewart 26 July [1879]. NLS, Acc. 9220 (1) (i). On the importance of measuring time in explorers' experiences in Central Africa, see Fabian 2000, pp. 55-58.

brain, making them less able to resist the severer attacks that came with change-over of the seasons". Two deaths occurred among the Europeans. "The fever" continued to trouble the missionaries immediately after the move to Bandawe. In Laws' opinion, fever was "endemic" in the district.[65] Rev. Dr Hannington, who was sent to relieve Laws in 1882, had to be invalided home after just a few months in the country, after *"the local fever assumed a critical type."*[66] Only in late 1883 were Laws and his wife able to return to Scotland, after the arrival of Dr William Scott, his wife, and Rev. J.A. Bain.[67]

Scott kept a private journal from September 1883 until his return to Scotland in May 1886. In his journal, Scott mentioned several cases of "fever" as well as slighter cases of "cold". Exposure to cold and damp conditions was linked to fever. He observed that in more severe cases patients were jaundiced. Scott did not once use the words "malaria", "miasma" or "zymotic poison", and did not discuss the aetiology of fever in detail in his journal entries. He also provided only a few details about the treatments he used.[68] Apart from fever and colds, the missionaries suffered heavily from diarrhoea, dysentery and stomach disorders. Other typical complaints included headaches, tapeworms, and toothache. The birth of the Scotts' baby boy in March 1884 brought more concerns for Scott, though during his first year the baby seemed to remain relatively healthy. Their second year in the country (from September 1884 to September 1885) was more difficult for the Scott family. Over the course of thirteen months, Scott recorded fifty entries relating to his personal health and illness, the most common of these mentioned that he had been in bed with fever for all or part of the day.[69]

In cases of prolonged or serious illness, recovery was sought through a trip to higher ground. At Cape Maclear visits to Blantyre had been a refreshing experience for missionaries. In Bandawe missionaries would visit the hill station in Northern Ngoniland.[70] In March 1885, the Scotts travelled to uNgoni after their baby had suffered from a severe attack of "Hooping Cough", and they believed that this change of location speeded the baby's recovery. The Scotts spent most of March in the hills, and enjoyed relatively good health. Mrs Scott and the baby remained at the hill station for an additional month.[71]

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65 See, for example, Bandawe Station Journal entries for April, 1883. NLS, MS. 7911; Livingstone 1921, pp. 177-178, 196.

66 Laws, quoted in *FCSMR* October 1882, p. 299.

67 *FCSMR* August 1883, p. 240 and April 1884, pp. 111-112.

68 Private Journal of William Scott, Bandawe, 1883-85. EUL, Gen.1942. Journal entries for September 1883-September 1884; 26-29 January 1884.

69 Ibid., journal entries for September 1884–September 1885. Mrs Scott's health was discussed in about forty entries, with fever being the most common ailment, although she also suffered from headaches and stomach troubles.

70 Ibid., journal entries for December 1884; Smith to Laws 22 December 1884. NLS, Acc. 9220, (1) (ii).

71 Private Journal of William Scott, Bandawe, 1883-85. EUL, Gen.1942. Journal entries for 25 February – 30 March 1885. Fifteen years later a writer in the *Aurora* claimed that whooping cough first appeared in the region in 1885, supposedly coming from Scotland in a box of used children's clothes sent to Bandawe. Scott's journal makes no mention of clothes at the time, but it is plausible that baby Scott was the first recorded case of this disease in the region. It was estimated that in 1896, nearly half

The climate in uNgoni was generally judged to be considerably healthier than that at the lakeshore. However, the missionaries at the Ngoniland outpost were often troubled by stomach disorders. In November 1882, Sutherland requested medicines from Laws to treat diarrhoea. The following year he blamed "too much indulgence in milk" for his diarrhoea and believed that wheaten bread was "the best cure". The orthodox treatment for dysentery in the mid-1880s was to administer ipecac.[72] Koyi and his wife, who joined him in early 1885, suffered from persistent ill health while at the outpost. Koyi made a requested from Bandawe at a time when there no European doctor was resident in uNgoni. Koyi was not always treated as an equal by Europeans in medical matters. When his quinine ran out in 1883, Koyi asked Sutherland for additional supplies. Sutherland tricked Koyi by making up *"the bitterest tonic I have for him so that he seals his lips after it."*[73] Mixing up a foul-tasting "medicine" was a standard missionary doctor and pioneer European ploy often used to deal with "medicine-eating" patients who were regarded as lazy and undeserving of true treatment. It is tempting to speculate that Koyi may have turned to Ngoni medical specialists before Elmslie's arrival, as there is evidence that in 1883 he was already acquainted with the Tembo brothers,[74] whose father was the nearest healer to the mission station and who was exceptionally friendly towards the missionaries. However, there is not sufficient evidence to explore the issue further here.

In early 1885, Scott and the recently-arrived Elmslie examined Mrs Koyi, but did not tell the Koyis that the apex of her right lung was partly destroyed. The doctors believed that if she had been told the truth, she would have left for home immediately. Scott and Elmslie were convinced that she would be "as likely to keep fairly well" in Ngoniland as at the Cape.[75] Elmslie, in turn, reported that he had found "nothing wrong with her lungs structurally", that he and Scott agreed that "no organic disease existed" and that Mrs Koyi suffered from chronic bronchitis, although she thought she was dying from consumption and refused to take the tonic Elmslie had prescribed.[76]

In May 1886, Elmslie wrote that Koyi had been in poor health since February, having suffered from low fever and a persistent cough for three weeks. Mrs Koyi was better by this time, but although Elmslie had not found any "progressive lesions", he believed now that she was "decidedly phthisical". Koyi died suddenly in early June, with the immediate cause of death being

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of the children affected in Northern Ngoniland died. See *The Aurora,* April 1900, p. 13.

72 Koyi to Laws 19 January and 18 April 1883. NLS, Acc. 9220 (2); Sutherland to Laws 14 November 1882, NLS, Acc. 9220 (1), (i); Sutherland to Laws 15 September 1883; Elmslie to Laws 12 December 1884.NLS, Acc. 9220, (1) (ii).

73 Sutherland to Laws 15 September 1883. NLS, Acc. 9220, (1) (ii).

74 Koyi to Laws 17 March and 18 April 1883, NLS, Acc. 9220 (2); Thompson 2000, pp. 115-117.

75 Scott to Laws 29 May 1885. NLS, Acc. 9220 (1) (iii); Thompson 2000, pp. 122-123.

76 Elmslie to Laws 9 June 1885. NLS, Acc. 9220 (1) (iii). Mrs Koyi came from a prominent Congregationalist family in the Eastern Cape. She was the daughter of Rev. Andries van Rooyen, who had been ordained as a minister in 1849. Thompson 2000, p. 100.

heart failure. Elmslie wrote that pericarditis had followed Koyi's lengthy fever, *"and extensive & rapidly increasing dropsy resulted"*. Elmslie was not able to rule out the possibility that Koyi had been suffering from tubercular phthisis, but stressed that the physical signs were not "very well marked." After her husband's death, Mrs Koyi returned to the Cape.[77]

At Bandawe, Scott suffered from a serious illness in July 1885. He wrote in his journal, *"I never had such a shaking before."* Three days later he contemplated his situation gravely: *"Still in bed much vomiting yesterday & weak today…Another birthday spent in bed. I am now 26 years of age. Oh! for much grace to spend the few remaining years that may be allotted to me in God's service and always under the sunshine of His presence."*[78] Life in Bandawe in the 1880s often seemed short and precious. Scott recovered quickly for a time, but was struck down with fever again two weeks later. On July 28, Scott's condition was at its worst:

> About noon I began to vomit watery matter followed by blood & continued vomiting every few minutes for a few hours. More and more blood coming, mouthfuls at the time. This was followed by two dysenteric purges & I was as weak as possible from the loss of blood. Poultices enemas & asturgent as well as opiates were applied with effect.[79]

The following day, both Scott and his wife were feeling better and *"thankful to God for having spared our lives for longer service."* Scott recalled in 1926 that by the time he arrived in Central Africa, the missionaries had noticed that those with the best mosquito "curtains" suffered least from malaria. It was thought that the curtain acted as a filter against the miasmata in the air.[80]

Although Scott had recorded several European deaths in the region during 1885, the missionaries at Bandawe had survived without casualties until late September. On 27 September, James Sutherland, the mission agriculturalist, was feverish, the following day he had a serious fever and was jaundiced and on 29 September, he died. This sudden death was a shock to Scott, who described Sutherland's final hours:

> Mr. Sutherland slept well all night. Felt weak in the morning & was slightly feverish. He got chicken tea several times & also quinine and brandy. He became slightly delirious in the afternoon. I was with him & he was desirious of going away with the steamer to bring us up sugar &c. These were his last words. He sat up to take some chicken tea & fell back again. breathed up a few times & was no more. His end was unexpected as he was only two days ill but his blood seems to have got quite disorganised, as well as having jaundice…[81]

Scott had noted that Sutherland's *"urine was very dark darker than blood, containing much albumen & blood colouring matter as well as bile."* Although it was clear that the fever was severe, Scott at first did not regard the illness to be life-

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77 Elmslie to Laws 10 May and 6 June 1886. NLS, Acc. 9220 (1) (iv).

78 Private Journal of William Scott, Bandawe, 1883-85. EUL, Gen.1942., journal entries for 10 and 13 July 1885

79 Ibid., journal entry for 28 July 1885.

80 Ibid., journal entry for 29 July 1885; Scott 1985, pp. 50-51.

81 Private Journal of William Scott, Bandawe, 1883-85. EUL, Gen.1942. Journal entry for 29 September 1885; McCracken 2000, p. 105.

threatening as the patient was perspiring freely and his bowels were active. The treatment administered was typical of the time, consisting of feeding, quinine and brandy as a stimulant.[82]

The very unpredictability and rapid development of malarial fevers and other fatal illnesses in Africa made them distressing and psychologically stressful for all Europeans, not least for the doctors to whom everybody turned for treatment. Some deaths occurred very unexpectedly.[83] There was an urgent need to discover why one patient died, whilst another survived. Details such as not wearing a helmet before an attack could make a huge difference in retrospect and, in light of the chill theory, could later be described as a fatal mistake that left the patient exposed to changes of weather and temperature.[84] Although highland stations and better houses largely believed to be healthy, recurring fever attacks puzzled the missionaries.[85] Some deaths or serious illnesses could be explained by "constitutional" factors, but in other cases, healthy-looking men died quickly and unexpectedly.[86]

The Scotts returned to Bandawe in early December of 1885. They found that the European staff had not been well, and that Drs Cross and Elmslie, as well as Smith and Rollo, had suffered from fever and diarrhoea. Soon Scott himself was feverish and contracted a sore throat that prevented him from preaching. During the month of December, Scott recorded fourteen entries of European illness in his diary. On Christmas day, he wrote: *"We are all rather seedy & not in much spirit for Christmas."* Four days later they learned that Rollo had died in Ngoniland. Scott did not immediately tell his wife, as she was still suffering from fever. Scott and Smith talked of their grim situation and *"prayed guidance in our peculiar circumstances. May it be granted us and the Kingdom advanced in this dark sinful country."*[87]

Scott does not record in his journal exactly when he and his wife decided to leave the country, but a more positive entry on New Year's Eve suggests that at this time they were still planning to stay. However, on 7 January Elmslie wrote to his mother that the Scotts were leaving immediately on the grounds of Mrs Scott's pregnancy, a decision that Elmslie deplored as cowardice. At that

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82 Scott to Laws 4 October 1885. NLS, Acc. 9220 (1) (iii).

83 For example, Stewart CE reportedly died suddenly in his chair after six days of illness, without ever speaking about his illness. Munro to Laws 12 September 1883. NLS, Acc. 9220 (1), (ii).

84 On tropical helmets as "the great cork insulators against the tropics" see Jennings 2002, p. 250.

85 For example, in December 1884, Smith wrote to Laws from uNgoni where he was sent to recover, *"I can't understand how I shd take relapse after relapse in this most comfortable house"*. Smith to Laws 30 December 1884. NLS, Acc. 9220, (1) (ii); Private Journal of William Scott, Bandawe, 1883-85. EUL, Gen.1942, journal entries for 5 to 16, 18 and 21 October 1885.

86 Cross to Laws 4 July 1885. NLS, Acc. 9220 (1) (iii); Cross to Laws 26 January 1886. NLS, Acc. 9220 (1) (iv). Cross believed that Dr Hannington's illness in particular, was due to "constitutional peculiarity" rather than the climate. Cross had interviewed Hannington in Scotland.

87 Private Journal of William Scott, Bandawe, 1883-85. EUL, Gen.1942, journal entries for December 1885

time the new recruits at Bandawe were suffering from fever.[88] Scott recorded twenty-two entries of European illness during January. The Scotts themselves experienced recurring attacks of fever, and a major reason for their departure seems to have been the illness of their baby, who suffered from severe diarrhoea. The new doctor, Cross, Rev. Bain and Smith appear repeatedly on the sick list for January 1886.[89]

The Scotts left by steamer on 29 January.[90] Soon after arriving in the Shire Highlands, Scott suffered an almost fatal blackwater fever attack. He ran a fever and suffered from dysentery, and vomited blood on 8 February. He seemed to be showing signs of improvement by 17 February. However the next few days were among the worst, and Scott was able to write only very short entries:

> Got up this morning & was fairly well till lunch time then had to go to bed & was very, very ill – Shivering very much passing extremely dark urine and getting quite yellow in the skin. temp 105. pulse 130.
>
> Bad all night – got injections. Mr McIlwain & Mr McCallum with me all night. May God be merciful to me in my loneliness.[91]

By 22 February, the fever had subsided but Scott knew that he would "require a long time to recover". He was able to walk short distances by 28 February and the Scotts boarded the steamer Lady Nyasa on 2 March 1886 and began their journey towards the coast.[92] Scott gave a more detailed retrospective account of his illness in his memoirs:

> My third attack was…a regular blackwater fever one. It came on two days after a long march in the wet season where I was again and again soaked through. It seemed like an ordinary malaria attack until I saw my urine. In a few hours I was in a very weak state. I had the good fortune to be near a medical man. I got stimulants. Within the first 24 hours a good bottle of champagne, which did wonders...The fever left me in a few days, the urine cleared up, but I was unable to walk about for about a month and it was advisable for me to no longer remain in the country…[93]

It is clear that the Scotts had decided to leave the country before the blackwater fever attack in Blantyre, but in his memoir Scott gives the impression that it was this illness that forced him to leave. He does not mention his wife's pregnancy or his family's health in this context. After the Scotts' departure, there was heated controversy among the Livingstonia missionaries as to whether Scott had had sufficient grounds to resign. Elmslie, Bain and, possibly, Laws all believed that Scott did not have sufficient grounds for resignation. Elmslie

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88 Ibid., journal entry for 31 December 1885; Elmslie to his mother 7 January 1886. NLS, Acc. 9220 (1), (iv).

89 Private Journal of William Scott, Bandawe, 1883-85. EUL, Gen.1942, journal entries for January 1886. On 26 January, station journal reads: *"We are all on our feet today, not a common occurrance in these sickly times."* Bandawe Station Journal entry for 26 January 1886. NLS, MS. 7911.

90 Ibid., journal entry for 26 January 1886. Cf. Bandawe Station Journal, entries for January 1886. NLS, MS. 7911.

91 Ibid., journal entries for 19 and 20 February 1887.

92 Ibid., journal entries for 22 February to 2 March 1886.

93 Scott 1985, p. 51.

privately accused Scott of cowardice and leaving ill colleagues at Bandawe during his long trips to Ngoniland and Blantyre. He pointed out that the recently deceased Sutherland had been in the country for five years and had never been given health leave for a month, even when Elmslie had applied for it on his behalf. Bain thought that Scott had violated his contract, and that he should not be appointed again.[94] Certainly, Scott's departure stirred up considerable bitterness and resentment among the remaining missionaries. Both McCallum and Smith demanded that they too needed to leave on health grounds. Smith had suffered from an "unusual amount of fever this year" and McCallum complained "greatly of a painful liver".[95]

Scott's journal from 1886 and his memoir of 1926 suggest, upon careful reading, that the health of his whole family was a crucial factor in Scott's decision to resign. However, he could honestly say that he had been given professional advice to leave the country after his nearly fatal bout of illness in Blantyre, and it was this fact that he stressed in retrospect. The controversy surrounding Scott's departure highlights the importance of medical opinion in deciding whether a missionary could go home respectably mid-term or not. Mission doctors wanted sole authority in all matters concerning illness and health, but in reality laymen often had considerable influence. A complaint could be made or a rumour started by any missionary, although medical men fiercely defended their authority over issues of health.

5.3 Treating colleagues and family

TABLE 7 Livingstonia missionary deaths, 1875–1900[96]

1875-1880	1881-1885	1886-1890	1891-1895	1896-1900	Total
3	3	6	5	3	21

During the period 1886–90, the Livingstonia mission lost several of its agents and their family members. After a number of deaths in 1886, the Committee decided that all recruits should be issued with a medical certificate prior to their appointment.[97] Many of the deaths at this time were in retrospect attributed to blackwater fever; in the 1880s, however, the diagnoses and the terminology used by doctors varied. Scott, in a letter to Laws, described how Sutherland

94 Elmslie to his mother 7 January 1886; Bain to Laws 1 September 1886, NLS, Acc. 9220 (1), (iv).

95 Elmslie to Laws 10 August 1887. NLS, MS. 7890, 166.

96 Including Scottish and Xhosa missionaries and missionary wives. Compiled from Livingstonia Staff-Book, NLS, Acc. 7548 D 73; Fraser 1915. In addition, at least eleven missionaries were invalided home. Between 1875 and 1900, total of eighty-one agents were appointed at Livingstonia. Between 1901 and 1929, three Europeans in Livingstonia died, all missionary wives.

97 Koyi, McEwan, Rollo and Sutherland died in 1885-1886, Mrs Cross and Mr Mackintosh in December 1886- January 1887, and Rev. Bain in 1889. Laws, *Livingstonia Mission, Five Years' Work 1886-90.*; Livingstone 1921, p. 221; McIntosh 1993, p. 95.

"seemed to be attacked by Haemoglobunuria as well as jaundice." Before blackwater fever was clearly defined in the 1890s, symptoms and disease were often confused.[98] Generally, fevers were classified as intermittent, remittent, bilious, haemogloburianic or various combinations of these. MacAlpine recalled that during his first twelve months in the country he suffered from intermittent fever twenty times. Intermittent fever was, however, considered to be less dangerous than remittent fevers.[99]

In serious cases, the patient's temperature was constantly monitored, and doctors kept detailed and extensive notes. In the case of Rollo's week-long fatal illness at the Ngoniland station, Elmslie, Koyi, and McCallum watched the patient in turn and recorded his temperature every hour. Perspiration was seen to be the key to reducing temperature, but in Rollo's case attempts to induce perspiration failed. Elmslie claimed that this was largely Rollo's fault, as he would not allow himself to be covered with bedclothes. The patient complained of oppression in his breathing and feared he was suffering from heart trouble. Elmslie gave a *"mild aperient which dispelled the oppression"*, on Tuesday. The patient came *"fully under the influence of quinine"* on Wednesday and his dosage was increased to ten grains, given every two or three hours. The patient was fed a "chicken infusion" three times a day from Wednesday onwards. When Rollo's temperature continued to rise on Friday night, Elmslie tried to lower it with "cold affusions". The patient's temperature varied between 102.6 and 105.8 degrees Fahrenheit on Saturday, with affusions bringing only temporary relief, and further weakening Rollo.

From Wednesday to Friday the patient's *"bowels acted about 8 times in 24 hours"*: the stools being "mostly bile" but with plenty of water. His urine was red and his spleen was "enormously enlarged", but his liver seemed to be normal. On Saturday, Elmslie had a bout of fever and could not inspect Rollo's urine. The patient was found to be "comatose or cataleptic" on Sunday morning. Elmslie applied sinapsisms, and Rollo subsequently regained consciousness. At this point, Rollo's pulse was "very irregular but full". Elmslie administered digitalis, which "never acted". The patient was

> quiet & sometimes speaking sensible till 7 pm, when he got comatose & we could not rouse him after 3 hours trial of various agents. at 8 pm he turned violently delirious & toward the morning had to be strapped down but he died peaceably.

The case was extremely distressing to those missionaries at the station who had been treating Rollo for a week. The fact that Elmslie used the plural pronoun when discussing therapeutic decisions and actions, reveals how the doctor and laymen worked closely together, and that the young doctor did not want to

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98 Scott to Laws 4 October 1885. NLS, Acc. 9220 (1) (iii); Cross to Laws 26 January 1886. NLS, Acc. 9220 (1) (iv). Blackwater fever was not included in standard British medical textbooks until the 1890s. Gelfand 1957.

99 In 1894, Laws observed that MacAlpine's number of fever days set a record, while Elmslie had comforted the patient with a dry remark: *"I see you are bilious like me; well, never mind, bilious folk live long"*. "Biographical account of life & work in Bandawe, 1893-94", p. 3. EUL, MS. 3086. 4. See also *FCSMR* April 1894, p. 81.

present himself as being solely in charge. Rollo had been a most difficult patient and in retrospect Elmslie believed that this has been due to *"a lesion of the brain."* The patient had been

> most persistent in requesting impossible medicines drink (not spirituous) & diet. He reasoned out to me what I should do and wd. never give in to try & sweat. We were annoyed because I could not do anything but rebut his requests & sometimes he would cry... [he] would allow me to do nothing sometimes until he was assured it would do him good.

The patients' delirium was "very fierce" and most of the time he was incomprehensible. On Sunday morning, however,

> when he came back to speech his first words were " I am dead and I am in hell" & began a fearful picture of God having deserted him. Of course you will see at once what gave this idea to his delirious mind = mustard.

Elmslie had repeated Scripture quotations, which had calmed the patient somewhat. The case had been so traumatic for Elmslie that he had been unable to write to Rollo's father to inform him of his son's death.[100]

The most personal and distressing cases for missionary doctors involved their own wives or children. Mrs Cross died very suddenly in December 1886, after nursing her husband.[101] In September 1887, when Mrs Elmslie barely survived a difficult "confinement" and their baby died, Elmslie wrote to Laws: *"Oh I wish you were here to consult with. I never had a case like that…I never had a trial like this"*. Mrs Elmslie had to be given chloroform by Lovedale evangelist George Williams.[102] A year later, while again pregnant, Mrs Elmslie developed a severe fever and stomach troubles, and was *"reduced to skeleton"*, Elmslie and Laws maintained a frequent correspondence and agreed on the line of treatment to be followed. While his wife was recuperating, Elmslie told Laws that he was convinced that *"Morphia & mustard were the means of saving her."*[103]

Bain died in 1889 while under Laws' care. A year later, Laws attributed his death to "fever and nephritis",[104] although later the case was suspected to have been blackwater fever. Laws was distressed while treating Bain and he consulted Elmslie about the case. In his reply Elmslie agreed with the methods of treatment, confirmed Laws' diagnosis and approach, but cautiously mentioned that he had successfully freely purged a similar case in 1885. Bain

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100 Elmslie to Laws 29 December 1885. NLS, Acc. 9220 (1) (iii). Rollo had not complained of "head symptoms", except *"those referable to Quinine"*. When these occurred, Elmslie started giving quinine at long intervals, and when the symptoms diminished, Elmslie returned to *"5 gr doses of neutral Sulphate the other being always vomited."*

101 Bain to Laws 27 December 1886. NLS, Acc. 9220 (1) (iv). Bain thought the cause must have been heart disease, and Dr Cross or Bain did not have time to do anything to treat her.

102 Elmslie to Laws 18 September 1887. NLS, MS. 7890, 196.

103 Elmslie to Laws 9 and 10 September 1888, n.d., NLS, MS. 7891, 165, 167, 225. In an undated letter of 1888, Elmslie could happily report that his daughter had been born after an easy confinement.

104 *The Livingstonia Mission. Lake Nyasa and Uplands, East Central Africa. Five Years' Work – 1886-90.*

had jaundiced rapidly, which Elmslie saw as a clear sign of the *"breaking down of blood corpuscles in the circulation"*. Elmslie suspected that the patient had kidney damage, but admitted that none of his medical reading had solved the issue yet. Laws did not Elmslie's response in time, as the following day Elmslie wrote to Laws again and expressed his sorrow at hearing of Bain's death and his regret that he had not been able to help professionally.[105]

Elmslie thought that Bain would have probably recovered if his kidneys had been healthy, but that they had *"failed to compensate the liver condition"*. He assured Laws that he (Laws) had used morphia both *"wisely and profitably"*. Elmslie offered his collegial support and sympathy, and wrote a frank admission of the weakness and uncertainty felt by a doctor: *"I can realize how you feel in losing such a valuable life…Did you wish you were ignorant of medicine & so not have the weight of responsibility? I have in similar circumstances."*[106] Laws seems to have believed that "wetting" and exposure had played a major part in Bain's illness. Elmslie stressed that in a case he had treated in 1885, the illness could have been avoided by wearing flannel and changing out of wet clothes quickly. Elmslie also suggested that poor diet might have contributed to Bain's illness and death.[107]

The importance of nursing – feeding and looking after a patient – became clear. During her short stay at Cape Maclear in 1879–80, Jane Waterston emphasised this in particular. In serious cases of malaria or intestinal infections, she advocated feeding patients eggs and milk beaten up with brandy. The missionary doctor effectively became a nurse in many cases, although Waterston, to stress her own professionalism, made a clear distinction in her writings, between "nursing" and "Doctoring". When she treated an engineer who worked on the ALC steamer on the Shire, Waterston wrote:

> I made him sleep in the cabin and never let him out without coffee and Quinine in the morning, and turned worksmate and baker as well as Doctor. I varied meals as much as possible…Vitality, energy, everything was at low ebb and never did I see a fellow more grateful for getting better and feeling some energy coming back. [His] delight over some bread and tea out of a tea pot was comical. He declares that it was the capital food that pulled him up so fast. I have also given him a lot of Quinine…[108]

Feeding, administering stimulants and, if necessary, staying with the patient throughout the night were aspects of therapy that could be carried out by

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105 Elmslie to Laws 17, 18 and 27 May 1889. NLS, MS. 7892, 98, 102, 110. Laws obviously had not "purged freely" in Bain's case, and afterwards wrote to Elmslie pondering his decisions about the Reverend's treatment. Elmslie had to reassure Laws that he had done everything possible.

106 Ibid., There were cases of morphine addiction among the pioneer European colonialists in Central Africa in the 1890s, but the Livingstonia archives do not refer to any addiction cases. Clearly this had been a fear for Laws, however. Vaughan 1982. On drugs and pioneer exploration in Central Africa, see Fabian 2000, pp. 66-68 and *passim.*

107 Elmslie to Laws 18 May 1889. NLS, MS. 7892, 102. Flannel was considered to absorb perspiration better than linen or cotton, and was the preferred underwear of the British in India. Collingham 2001, p. 87.

108 Waterston to Stewart 4 October 1879 and 14 February 1880. LJEW, p. 154-155, 166-168.

laymen and laywomen. When Laws was frequently incapacitated by illness during 1875 and 1876, he was treated and nursed by laymen, especially by George Johnston. Johnston was a carpenter, who on his return to Scotland graduated in medicine. In 1876 on the Zambezi, Laws was nursed by Stewart CE "with all the gentle tenderness of a woman".[109] The pioneering conditions in Central Africa blurred the boundaries between professionals and non-professionals, and made everyone a potential physician or nurse in times of crisis. Authority was dependent upon survival, age and experience in the tropics, where the professional and gendered roles of healers were more fluid than in the homeland.

It was essential for doctors that the patients should obediently follow their orders. When Mrs Elmslie first suffered from fever in late 1886, Elmslie was glad that she turned out to be *"a good fever subject with a temp of 105°"*. This comment should be understood in light of the fact that those patients suffering from high fever and serious illness could become delirious and could sometimes have to be restrained, as had been the case with Rollo. It should also be noted that doctors and laymen alike could have been under the heavy influence of various prophylactic or curative drugs such as laudanum, opiates, arsenic, quinine and alcohol.[110] Laws and Elmslie appear to have been scrupulously careful in their prescriptions. However, there is little evidence documenting the quantities and frequencies of medicines taken and prescribed by other missionaries.

Blackwater fever crisis and the use of quinine

For the missionaries, the most mysterious fever of the 1880s was marked by blood in the urine. This fever was described as haemogloburianic fever and was later commonly known as blackwater fever. In 1890, Dr George Henry wrote to Laws and described having suffered from a "very virulent type" of fever and passing black urine for three days, but Henry did not use the term "blackwater

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109 Livingstone 1921, pp. 82, 112. According to his biographer, fearing that he was descending into coma, Laws asked Stewart to apply mustard blisters to neck, back, and calves of legs. Stewart thought the measure too drastic, but obeyed the gravely ill doctor. The treatment seemed to work: "The deadly lethargy left him and profuse perspiration set in". In his journal, Stewart described the treatment in detail: Sunday night, ten grams of "Divers powder" and ten grams of quinine. Monday night, four grams of"Rouser", three grams quinine, fifteen drops laudanum. Tuesday mid-day, ½ teaspoonful of "Sweet Spirits of Nitre", at night mustard plasters for 45 minutes, twelve drops of "Muriate of Morphia", ten grams Quinine. Wednesday, improvement, *"pain nearly gone but very weak in body and unable to think"*. At night five grams of quinine, a teaspoonful of "Sweet Spirits of Nitre". Thursday morning *"patient better, able to eat breakfast and dinner. 5 grams quinine at night."* Thompson (ed.) 1989, p. 27.

110 Elmslie to Laws 5 November 1886. NLS, Acc. 9220 (1) (iv) Missionaries to Laws, 1886-90; for delirium and restraint see also Laws' diary entry for 1 April 1880. EUL Gen. 561/2. Fabian 2000, pp. 63-71. In 1876, James Stewart CE mentioned he treated his "old acquaintance of colic" with a dose of rhubarb and ten drops laudanum. Thompson (ed.) 1989, p. 20.

fever".[111] Henry pronounced that the cause of his wife's death at Livlezi Valley had been blackwater fever in November 1892; she had survived her first attack, but had a fatal relapse after two weeks and died within twenty-four hours. At the turn of the century, this disorder was believed to be the result of quinine overdose. Scott wrote in 1926 that he became convinced that the quinine poisoning theory was not valid on the basis of his experience, for he personally loathed to take quinine and nevertheless had suffered from blackwater fever.[112]

Quinine was not universally accepted or regularly used as a prophylaxis even among the doctors of the 1880s. Swallowing quinine was difficult, and large doses could result in deafness.[113] Quinine tablets had been introduced by the mid-1890s and most Livingstonia missionaries used prophylactic quinine regularly, although there were variations in recommendations about frequency and dosage. At the Ngoniland hill station in 1894, Elmslie preferred small doses, taking two to three grains of Burroughs and Wellcome "tabloids" of quinine every second or third morning, while Cross, in his handbook of health for European travellers (1897) recommended a two-grain dose of hydrochlorate of quinine every morning and evening. At the Bandawe station, MacAlpine believed that a *"daily dose of quinine under the blessing of God"* secured adequate health, while also noting with irony the similarity between the various and conflicting missionary ideas about "healthy" sites and the African "superstitious" beliefs that missionaries frequently mocked.[114] In his annual medical report for Bandawe for 1895, Dr George Prentice remarked that there had been little need to treat the European staff, as everyone had been taking their preventive quinine. Laws firmly believed in the use of quinine as the "sheet anchor" of treatment against all forms of fever including blackwater.[115]

Blackwater fever often seemed shocking to doctors. In October 1895, Cross described the death of artisan missionary Hugh Steven from a "Bilious Haemoglobionose fever" after three days of illness. The patient was suffering from a kidney disorder, *"whole body yellow as a lemon"*, and for the last two days

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111 Henry to Laws 14 July 1890. NLS, MS. 7893, 145. Of the UMCA missionaries on the eastern side of the lake, twenty-eight died during the 1890s. Of these deaths, twenty were attributed to malarial fevers, and in particular blackwater, which was responsible for sixteen malarial deaths according to Dr Howard of the mission. Good 2004, p. 129.

112 Henry to Laws 7 November 1892. NLS, MS. 7896, 157; Scott 1985, pp. 50-51. Scott's comment has to be seen in the context of the 1920s when blackwater fever was a firmly established disease in Western medical discourse and the debates about the role of quinine had been ongoing for decades.

113 In 1887 Elmslie complained to Laws that he could not even swallow a pill without wafer papers, much less quinine. Elmslie to Laws 6 June 1887. NLS, MS. 7890, 127. Gelfand 1957, p. 137.

114 *Report of Foreign Missions for 1894,* p. 78; Cross 1897, p. 95. Travelling in Central Africa in 1892, Dr James Johnston recommended a daily dose of five grains when approaching "malarious districts". Johnston 1969, p. 347; MacAlpine to Smith 28 December 1894. NLS, MS. 7877, 213. MacAlpine stressed that the fact that so many Europeans had died at the station was because many seriously ill and dying patients had been transferred there from elsewhere. The association between location and health in African thought was frequently referred to in the context of apparent distrust of hospitals.

115 Medical Report for 1895, NLS, MS. 7878, 304; *The Aurora,* June 1899, p. 19.

"not a half hour passed without the most violent retching and vomiting". Cross concluded that "bilious poison" had spread throughout the patient's body before his death.[116]

Theories about the origins of blackwater fever and methods of treatment varied, with the use of quinine remaining particularly controversial. The Livingstonia doctors suffered their own losses from blackwater fever: the deaths of Henry (in the Livlezi valley in 1893) and Dr George Steele (in uNgoni in 1895) were later attributed to this type of fever.[117] In February 1898, Laws had to send Dr Ramsay (who had only recently arrived at the station) home permanently after Ramsay had barely survived his second attack of blackwater in Karonga. To make matters worse, Dr Roby-Fletcher, who had only been in the country for a few months, died in Bandawe during the same month after what had seemed to be an ordinary attack of malaria. The layman missionary George Aitken, who tried to revive Fletcher, suspected that his death had been in part due to an overdose of quinine.[118]

The Livingstonia doctors, in general, relied heavily upon quinine in cases of blackwater, rejecting the idea that the disease was partly caused by quinine poisoning, as put forth by the grand old man of bacteriology, Robert Koch, among others.[119] Many Europeans never suffered from blackwater, but the disease tended to recur in those affected, often with fatal results. Thus, it was imperative to send home all Europeans who had survived their second attack.[120]

The doctors felt more confident about treating blackwater fever only after the turn of the century. In 1900, George Prentice placed his trust in quinine bihydrochlorate, a hypodermic case and a serum syringe from Burroughs and Wellcome: "*When a man is armed with these, Blackwater fever promises to lose many of its terrors.*"[121] In 1903, Elmslie wrote to Laws that Dr Hearsey, the medical officer at Zomba, had treated successfully twenty-three consecutive blackwater cases. Elmslie added that he personally had used a milk diet supplemented

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116 Cross to Smith 21 October 1895. NLS, MS. 7878, 290.

117 *Report on Foreign Missions for 1894*, p. 83; *FCSMR* September 1893, pp. 201-203; Elmslie to Laws 24 and 27 July 1895. NLS, Acc. 7548 D 67; Gelfand 1964, p. 240.

118 Laws to Smith 12 February 1898; Aitken to Smith 19 February 1898. NLS, MS. 7881, 8, 12.

119 *The Aurora,* June 1899, p. 19. In 1903, Prentice wrote: "*Quinine hurts the hearing and weakens the voice, but I have no sympathy with this outcry against it as the cause of black-water fever.*" Prentice to Daly 17 September 1903. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee, 1903, p. 125. Prentice suffered from both loss of hearing and voice, and clearly linked his ailments to regular use of quinine. From a modern perspective, Koch was partly right: today, blackwater fever is considered to be an autoimmune response that can follow an extreme case of falciparum infection and prolonged use of quinine. Honingsbaum 2001, p. 214.

120 Johnston 1897, pp. 179-180. Harry Johnston estimated that among the Europeans in British Central Africa during the early years of the Protectorate, the mortality rate following the first attack of blackwater was forty per cent, after the second, fifty per cent and after the third, seventy-five per cent. See also Elmslie to Laws 26 January 1904. NLS, MS. 7548 D 67.

121 Prentice to Smith 3 July 1900. NLS, MS. 7883.

with chicken tea to successfully restore digestion after episodes of blackwater fever.[122]

Feeding continued to be a crucial part of missionary therapeutics. In 1903, Prentice described the treatment of the critically ill artisan missionary William Murray in Kasungu. When Prentice and his wife arrived:

> ...we found Murray in high fever (nearly 104° Fahr.) and pretty weak. The fever culminated in severe attack of black-water on the Sabbath after our arrival, and nearly carried off our patient.
> During Sabbath, Monday, Tuesday and Wednesday...I had to watch him night and day. On the Monday the temperature fell slowly from 105° to normal, and the urine cleared...Monday night was an anxious one, as the patient was extremely weak. On Tuesday there was a slight improvement, but just after midnight he completely collapsed. I used champagne freely, and managed to keep the heat [sic.] going by means of it, digitalis and strychnine, and with daylight on Wednesday came fresh hope**...**

The patient was given raw meat juice and freshly prepared meat extract on Wednesday. He was able to sleep a little and the hiccough subsided. The Prentices were hopeful, but feared that the loss of Murray would have a serious impact upon the reputation of missionary medicine: *"We felt that it would be a great blow to our work here were we to lose Murray – the confidence of the native in us being to a certain extent dependant on our success or failure in our European practice."* The missionaries resorted to special prayer:

> ...in which we stated that we could not let Murray go, and asked God for His Name's sake in the eyes of the heathen, and for the good of His work here, He would spare our brother's life...since then progress has been gradual, but sure and satisfactory.[123]

Champagne, digitalis and strychnine were stimulants used to treat "collapse". Giving a patient meat extracts was deemed to be an essential part of the treatment. Ultimately, treating a serious case of blackwater fever prompted the missionaries to resort to special prayers after all methods of therapy had been exhausted. The missionaries felt that the success of their European practice was vitally important to the reputation of missionary medicine among Africans in a new district.

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[122] Elmslie to Laws 16 September 1903. NLS, Acc. 7548 D 67. Hearsey's *"medical treatment solely is Leg. Hydrarg. Perchlor. mxxx. sod. Bicarb gr x a q. zi. every 2 hours for 1st day ot two & every 4 hours after."* Blackwater fever remained difficult to diagnose. In 1921, Elmslie wrote of a "very serious" case, possibly blackwater or "very bilious" fever, with a continuous temperature of 103 degrees, "incessant sickness" and intermittent pulse. Elmslie gave several hypodermics of strychnine, with "good results". Elmslie to Laws 9 January 1921. MNA 47/LIM/1/1/36.

[123] Prentice 25 June 1903. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee, 1903, pp. 100-101.

Africans and European patients

There is an important group of actors conspicuously absent from most missionary narratives of European illness: Africans, both on the mission stations and in the countryside. Yet, many of the pioneer Europeans must have owed their lives to their African associates. The most obvious example would be the Africans who carried sick Europeans to the nearest doctor or a mission station, and who often covered great distances. Personal servants looked after their employers, and were responsible for feeding and nursing lone Europeans when they were sick. However, servants were scarcely mentioned in missionary accounts. Jane Waterston noted that she was alone "except for a native" at Captain Benzie's deathbed, giving an indication of how Africans simply did not count in most colonial narratives. Dr Boxer's description of his illness from 1901 is typical. On the way from Ekwendeni to Livingstonia he collapsed with "raging and bilious fever": *"The day following I was carried in and "deposited" on Dr Laws' verandah. Dr Laws and Mrs Laws were kindness in itself, and in about four or five days I was up and on my feet."*[124] The African carriers remain unnamed and invisible, along with the African servants employed in Laws' household.

Occasionally, however, Europeans did record the importance of their African associates to the maintenance of their physical and mental well-being. Laws' biographer recounted the doctor's serious illness during a boat journey on the Zambezi in late 1876: "He was soaked, sick, vomiting, suffering from dysentery, tortured by mosquitoes, wretched with wretchedness beyond words." Laws' boat crew had gone ashore and he was suffering alone until a senior crew-member, one of the original pilots of the mission steamer, returned with three roasted sweet potatoes for Laws. Laws tried to eat but could not, and thanked the man for his kindness. Laws remembered the aid rendered to him during his illness with gratitude for the rest of his life. In January 1877, on his way back to Livingstonia, Laws was seriously ill and was taken to Senhora Maria's house on the river where he was nursed by "Sam" and Stewart CE. The doctor was in a state of delirium and twice called for the attendant to bring his revolver. Sam ignored these calls until the patient asked for a drink of water instead. When Laws fell ill with dysentery en route to Chikuse's in 1886, Albert Namalambe and Chimlolo "nursed him with affectionate solicitude, the former sitting with [Laws'] head on his knee and fanning him unweariedly." On this occasion, Laws was helpless for four days.[125]

In his memoir, Fred Moir of the ALC recalled how a female servant, Chuanganya, helped and cheered Mrs Moir when she was ill at Mandala in the 1880s. She walked with Mrs Moir, sang to her, told her about African customs and stories, and *"cheered her in every way her loving heart could devise."* In 1900, Nurse McCallum described the case of an ALC agent who was dying in Fort

124 Boxer to Overtoun 5 November 1901. NLS, Acc. 7548 D 70. Letters to Livingstonia Sub-Committee, 1901, pp. 20-24.

125 Laws 1934, pp. 58-59. Livingstone 1921, pp. 110-112, 224. In Stewart's journal, there is no mention of Africans in the detailed description of Laws' illness. Thompson (ed.) 1989, pp. 26-27.

Johnstone and recounted how Tonga labourers there offered to carry him "day and night" to Bandawe to be treated by Dr Prentice. MacAlpine fondly remembered the care of his "machila men" when he was suffering from malaria and depression while travelling from Ngoniland to Bandawe. As Cairns has argued in the early period of colonial contacts, the weakness of Europeans contributed to a more equal relationship with Africans than was the case during the later colonial period.[126] Illness was a significant part of that European weakness.

5.4 Energy, psychology and morale

Psychological, moral and spiritual factors were all essential elements of the missionary doctors' theory and practice of hygiene (preventive medicine) in the tropics. For the pioneers, fighting "the fever" was both a moral and bodily issue. When in 1877 it appeared that the Xhosa evangelists were suffering more seriously from fever than the European missionaries, William Black argued that this was because *"their chief failing is on taking their sickness too much to heart – somehow they don't have the mental gist or stamina of a good hardy Scot who will face anything rather than be defeated"*. Malaria could also cause madness, and in the same letter, Black wrote that the "insanity" of Xhosa evangelist Isaac Wauchope seemed to be *"due more to moral than to malarious causes."*[127] It is not clear if the Xhosa, who were initially believed to be resistant to malaria, were entitled to the same amount of expensive prophylactic quinine as the Scots, but it is revealing how, in this case, perceived experiences of illness could create and reinforce racial identities and stereotypes. The idea that the African evangelists from South Africa were weaker than Europeans in the Central African climate contributed to their gradual removal from Livingstonia.

One of the most distressing aspects of "the fever" was its psychological impact and influence on social relations in the mission. In Cape Maclear Laws exclaimed:

> If only that cursed malaria...would be content with poisoning of the bodies of men, and would let their minds alone, half the jars of life here might be avoided...as an attack of fever approaches things look black and gloomy, the actions of companions are sure to appear distorted, and their motives apt to be misconstrued...[128]

Furthermore, one of the effects of "the fever" was that it "wore out brain power".[129] Keeping up the patients "spirits" and morale was a vital part of

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126 Moir 1924 [1923] p. 52; McCallum to Smith 29 January 1899. NLS, Acc. 7548 D 69, Letters to the Livingstonia Sub-Committee, 1898-1900; EUL, MacAlpine Papers, MS. 3086.4; Cairns 1965, p. 70.

127 Black to Smith 3 March 1877. NLS, MS. 7876, 176. For the importance of "hygiene", broadly understood, for European colonialists in Africa, see Fabian 1991, pp. 155-163.

128 Quoted in Livingstone 1921, p. 84.

129 Laws' diary entry for 22 March 1881. EUL Gen. 561/2.

pioneer missionary therapeutics. Different methods were used, but prayer and religious rituals were particularly important. When treating the delirious Laws in 1876, Stewart CE read the patient the Church of England sermon, and, in W.P. Livingstone's words, "the measured beauty of the diction, and the sequence of petition, seemed to calm the sorely distraught brain". In early 1890, Laws had fallen seriously ill with malaria and was prepared to die. Elmslie took the critically ill patient to the hills to recover. Elmslie first prayed with Laws, and then "to relieve his emotion" gave the patient "a dig in the ribs". Laws laughed, "and from that moment began to improve".[130]

Elmslie was worried about the health of a new missionary teacher in uNgoni in late 1889. The patient's symptoms included fever, constipation, weakness and a weak appetite. Elmslie treated him with a pill of quinine, iron and arsenic, which seemed to be helping after three days. However, the patient then suffered from an alarming fainting episode. Four days later, Elmslie wrote to Laws that the patient was steadily improving on the quinine–iron–arsenic pill. As Janet Oppenheim has pointed out, quinine, iron and arsenic were among the most effective nerve tonics in Victorian medicine. They were prescribed "to restore firmness to patients' collapsed nerves and to stimulate the production of the nerve force" in cases where patients was seen to suffer from nervous debility.[131]

Later, Elmslie provided Laws with a more detailed account of the patient's collapse and treatment, in which he placed considerable emphasis on psychological factors: *"He was very weak and has always been more or less in a state of terror"*. Elmslie provided warm clothes, hot water bottles, brandy and chicken tea for the patient, who was *"unconscious and more terrified than delirious"*, with an almost imperceptible pulse. After the patient was given stimulants for five or six hours, he got some sleep and was then removed to the doctor's house. When asked afterwards how he had ended up collapsed upon the floor, the patient recalled a *"mass of spiritual troubles and encounters with the powers of darkness."* Elmslie provided a psychological explanation:

> His mental condition may be the result of his weakness but I fear the emotional more than the substantial side of experience has been cultivated in the past and he has fallen flat when the stimulus it supplied has been cut off. The Y.M.C.A. is a sinner in this respect if it is as I remember it.[132]

Elmslie blamed religious emotionalism, fostered by the YMCA, for endangering the mental and physical health of a fellow missionary. "The emotional side of experience" had been excessively "cultivated" in the patient, and when the "stimulus" it provided was "cut off" in a moment of spiritual anxiety, he lost his mental and physical balance, which resulted in a dangerous collapse. At the

130 Livingstone 1921, pp. 112, 249.

131 Elmslie to Laws 22 and 26 November 1889. NLS, MS. 7892, 276; Oppenheim 1991, p. 111-112. Iron, arsenic, quinine and strychnine remained important tonics in Livingstonia into the 1920s at least. Laws to A. Fraser 9 April 1919. MNA 47/LIM/1/1/19.

132 Elmslie to Laws 7 December 1889. NLS, MS. 7892, 286.

end of the month, Elmslie was happy to report that the patient had improved in body and mind, and was back at work.[133]

In 1894, Laws argued that a lay missionary he had been treating should be sent home, on the grounds that *"an attack of fever coming on him while in a low nervous condition, will not only make him excessively irritable & unfit for work, but might lead to a complete breakdown…"*.[134] If missionaries' "nervous conditions" were not in order, they would be both at a higher risk and a greater burden to their colleagues during episodes of fever. Maria Jackson and Margaret McCallum, both trained nurses as well as teachers, arrived at Livingstonia in November 1897 after a trying journey during the hottest season. They made a promise to look after each other and to warn the other when *"we see symptoms of becoming exacting or of our tempers becoming affected by the climate, or anything of this description setting in."*[135] After starting her work at the newly founded Livingstonia Institution in Khondowe, Miss Jackson wrote:

> This has been an unfortunate day, everybody seems to have been stupid and the girls troublesome,...everything...has gone wrong. I suppose this really means that I have had a touch of fever. It is a curious thing this fever...Sometimes one feels a curious lazy aching weariness never experienced at home, when everything is trouble, and if it were not for the genuine backache and headache one might be inclined to set it down to sheer laziness. It is a most unpleasant sensation, worse to bear than actual pain...I have always the provoking feeling that with a little more energy I could shake it off, yet somehow the right amount of energy is always lacking, no matter how much quinine you swallow.[136]

Jackson experienced fever as a lack of energy and tiredness unknown to her in Scotland. Fever could be even mistaken for laziness, which was a serious sin for a Presbyterian.

Doctors resorted to Easton's Syrup to provide energy and improve appetite.[137] This was the case with Elmslie, in 1894, when he was treating a female missionary with complicated symptoms. In this case, as was typical in Victorian medicine, nervous symptoms were connected to "feminine disorders" of the reproductive system. Elmslie wrote that the patient, who had serious pelvic pains and diarrhoea, probably had a "disordered nervous system", and that: *"Whatever is the condition of the uterus & ovaries it is evident her general health is seriously impaired, and she does her best to hide her weakness."* Elmslie asked for Laws' opinion, adding that he had not performed a vaginal examination of the patient.[138] As her pains increased, and she could not tolerate "iron such as in Easton's Syrup", Elmslie gave her "arsenic and bitters" as a tonic and opium as a last resort. The patient's condition continued to worry the doctor, who observed that her periods were difficult and painful. However, Elmslie would

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133 Elmslie to Laws 27 December 1889. NLS, MS. 7892, 294.

134 Laws to Smith 10 September 1894. NLS, MS. 7877, 152.

135 Jackson to Smith 8 November 1897. NLS, MS. 7880, 127.

136 Jackson to Smith 22 August 1898. NLS, Acc. 7548 D 69, Letters to the Livingstonia Sub-Committee 1898-1900, No. 77.

137 Easton Syrup was a Victorian Scottish invention, devised by John Easton, Professor of Materia Medica in Glasgow University. Robertson 1998, p. 44.

138 Elmslie to Laws 23 November 1894. NLS, Acc. 7548 D 67; Oppenheim 1991, p. 181.

still not make any manual examination as he feared that it could lead to "a habit", a reference to masturbation.[139] Elmslie was unable to discuss this case with the man engaged to the patient even though he was also a missionary doctor. As Oppenheim has pointed out, Victorian doctors had difficulty discussing what were perceived to be elements of sexual deviance in women's neurotic disorders. A few months later after the death of the patient's fiancé, Elmslie performed a manual examination of the patient. The prescribed treatment consisted of "brisk purgatives" at the beginning of the period, hot hip-baths and hot bottles, and tonics for the nerves. The patient still suffered from "general weakness" and a poor appetite, and Elmslie remained unsure how to proceed.[140]

The nerves and will-power of missionaries, especially unmarried women, were a concern for mission doctors, at the time when single women missionaries were being appointed at Livingstonia. In Victorian medical theory, female will was generally believed to be weaker than male will. In 1897, Elmslie wrote to Laws that he had been favourably impressed by Miss Jackson, then a prospective mission nurse, who was studying a diploma in midwifery in Glasgow. Such an experience proved, Elmslie was sure, that she was not *"very backward in mental power."*[141] Training and practice in medicine and nursing was only for the mentally strong.

Maria Jackson wrote, in March 1899, that because of a "good many causes" the missionaries' "temper" had a *"tendency to degenerate in this land; but this is a delicate subject."* She stressed that the missionaries needed prayer, and because of divine support, the work would progress *"no matter how hopeless the missionaries are."*[142] Africa itself was regarded as a potentially degenerative factor influencing the missionary mind and temper, but prayer and careful living were regarded as effective means of securing mental health. Maintaining mental well-being was, in itself, one of the preventative measures taken against malaria. Margaret McCallum wrote to her old Highland pastor about the *"many depressing influences of climate, health and work"*. She stressed her feeling that the mission's work was not sufficiently appreciated by the Scottish public at a time when many missionaries died or were invalided home, and that new recruits and a lack of funds added to the stress the missionaries were under. Loneliness, sorrow for dead and invalided colleagues and a feeling of abandonment by the Christian community at home all contributed to and were made worse by the experience of illness. Feeling ill often made the missionaries more aggressive and quarrelsome towards each other and everyone around them. However, the rapid recovery typical of milder fever attacks was experienced as a sudden

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139 Elmslie to Laws 7 January and 10 June 1895. NLS, Acc. 7548 D 67.
140 Elmslie to Laws 3 August 1895. NLS, Acc. 7548 D 67. Oppenheim 1991, pp. 204-206.
141 Elmslie to Laws 21 July 1897. NLS, Acc. 7548 D 67; Oppenheim 1991, pp. 181-182.
142 Jackson to Smith 30 March 1899. NLS, Acc. 7548 D 69, 85.

surge of well-being and gratitude towards those who were caring for the patient.[143]

Laws was firmly convinced that mental, moral and spiritual well-being were crucially important to the physical health of missionaries. Conversely, physical illness could injure moral and spiritual condition, and contribute to religious doubt and feeling of abandonment. Laws, who was by this time the Moderator of the United Free Church and a legendary missionary, warned new missionaries in 1908 that, *"There is many a Christian missionary who feels as if deserted by the Master when that feeling really is due to his physical condition."*[144] When Mrs Mackenzie was preparing to travel to Livingstonia in 1900, Laws suggested that she should take good books and musical instruments with her to "keep her spirits up" in Africa.[145] In their treatment of colleagues, the doctors held the "spirits" of their patients to be crucial.[146]

Extreme changes in health – experienced as a feeling of physical disintegration and reintegration to wholeness, from fever to intermission or recovery – have parallels in the spiritual and religious sphere: feeling of doubt, lack of belief, loss of faith, replaced by sudden, joyous certainty of the love of God – from doubt to faith. Experiencing fever as a patient and physician and surviving it or treating it, could reinforce a missionary's religious faith and their sense of providential mission. Describing the long and difficult treatment of Murray, Prentice wrote:

> What nights Sunday, Monday, and Tuesday were can only be understood by those who have had experience of African fevers, who have broken the back of the fever only to see the patient slipping away through extreme exhaustion, who have listened to the midnight rattle in the throat, the ominous hiccough, and felt the fast-failing pulse! How one loathes the African night at such a time! How eagerly one listens for the first cockcrow, watches for the first streak of dawn! So also in the spiritual sphere! The long, cold, clammy night, when our hearts fail us! The dawn! The rising of the Sun of Righteousness with healing in his wings![147]

A strong spiritual experience of God's presence could help a missionary cope with illness. Conversely, shattered health could force missionaries to leave the field, sometimes entirely losing faith in their personal mission in the process.

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143 McCallum to Graham 23 October 1898. NLS, Acc. 7548 D 69, Letters to the Livingstonia Sub-Committee 1898-1900, 80. On effects of malaria, cf. Honigsbaum 2001, pp. 20-21.

144 Laws, quoted in *Proceedings and Debates of the General Assembly of the United Free Church of Scotland,* 1908, p. 113.

145 *Life and Work,* October 1934, pp. 391-392. EUL, Gen. 562.

146 See Elmslie to Laws, n.d. and 27 July 1895. NLS, Acc. 7548, D 67. When Mrs Boxer was seriously ill in September 1905, Elmslie noted with concern that "She is a puzzle & begins to lose heart now." Elmslie to Laws 11 September 1905. NLS, Acc 7548, D 67. Mrs Boxer's condition improved somewhat, but she died on her way out of the country.

147 Prentice to Daly 25 June 1903. NLS, Acc. 7548 D 70, Letters to Livingstonia Sub-Committee, 1903, pp. 100-101. Missionary language linked African nights to darkness and illness; and in African oral literature, the oppositions between night/day and life/death are also marked, and the night is frequently associated with sickness. This may be, according to Soko, one of the reasons why certain rituals connected to spirit possession therapy take place at dawn or at daybreak. Soko 1991, p. 32.

Allan Simpson, a missionary engineer and layman doctor, described his feelings during a critical illness to Laws:

> When I came to my worst...I had prepared myself to a fatal termination & I hope when I come to die that Gods love will not be clouded from me in the last hours by torturing bodily pains. Things seemed very dark to me during my worst. Heavens sweet influence seemed all gone. But now all is again bright.[148]

Physical, moral, mental and spiritual spheres were all emphasised in Laws' hygienic regime, and these spheres were linked by the concept of energy. The Institution was sited at Khondowe not only because hills were recognised to be less malarious, but also because Laws believed that the cooler climate would stimulate both mental and physical work with "less expenditure of energy".[149] Work and energy were for Laws inseparably interconnected, and properly measured work was essential component of health.

Working off the fever

In Livingstonia, the idea of countering fever with work lasted, in some form, until the turn of the century. E.D. Young had believed that fever rarely struck those who were on the move, working or exerting themselves. Remaining "idle on one spot" was considered to be particularly dangerous. A fear of idleness stemmed in part from the Protestant work ethic and the idea of laziness as sin. For Protestants, laziness had been for centuries typically attributed to pagans, Catholics and colonial natives.[150] Young believed that *"The effect of fever poison is to make you languid and indisposed to bestir yourself. Excitement will operate beneficially upon you..."*[151] This was the wisdom of the earlier generation of explorer-travellers in Africa and this had influenced Laws and other pioneer missionaries. Work, if correctly regulated, was believed to be beneficial excitement for both the body and mind. Laws sought to maintain his personal health and "spirits" through constant employment. According to W.P. Livingstone, during his first year in the country, Laws' worst day was "one on which he had given himself a holiday". He was only "restored to equanimity" by going hunting.[152] However, in 1876 Stewart and Laws reduced the missionaries' hours of work for health reasons. Under the new timetable, missionaries worked for seven hours on weekdays and had Saturday afternoons free. "Ample leisure" was seen to provide better health and morale.

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148 Simpson to Laws, n.d. [1879]. NLS, Acc. 9220 (1) (i).

149 In 1875, when the pioneer party was travelling up the Zambezi, Laws was worried about one of the artisans: "Rather weak physically, his lack of mental energy makes him a bad subject for the toil before us." Laws to Dr Mitchell 9 August 1875. NLS. MS. 7876, 23; Laws 1934, p. 146.

150 Fabian 2000, p. 58. See, for example, Alatas 1977; Burke 1997, p. 100.

151 Young 1877, pp. 43,186.

152 Livingstone 1921, pp. 84-85. Hunting was a form of sport accepted in early Livingstonia because of its practical value in supplementing the missionaries' food supplies. Hokkanen 2005, p. 754.

Working at night, and a lack of adequate rest was believed to be particularly perilous for health.[153]

Because fever was attributed to malarial miasmata from the soil, agricultural work and digging the land was regarded particularly dangerous. After the death of Rollo (an artisan generally regarded as a man in excellent health) John Stephen instructed Laws in 1886 that: *"All Europeans should avoid working with the spade turning up new ground in digging...some gasses which come out of the earth which is poison to new men..."*[154] Tilling the soil was regarded as being especially dangerous for new recruits who had not yet become acclimatised to the Central African climate. Long after the miasmata theory had been discarded, Laws held that the climate in Central Africa, unlike that of South Africa, prevented "European muscle" from competing with the African in labour and crafts.[155] Such beliefs could reinforce both the idea of African survival as the working class in their own land and the European role as colonial supervisors and overseers.

However, suitable work was always regarded by Laws and Elmslie to be useful for Europeans in order to fight fever and other illnesses. In 1882, Laws wrote in his diary: *"Had little fever but easily exhausted"*, suggesting he had "exhausted" the fever with exercise, medication, or both. Producing perspiration – whether through exercise, vapour baths or other means – was one way of exhausting fever. In June 1887, Elmslie described his attempts to "work off" the fever.[156] "Working off" fever was championed at Livingstonia, and was a variation of the general colonial consensus on the need for exercise in the tropics. Playing games and sport were also regarded as excellent ways for securing health. This emphasis upon sports and games was typical of the middle-class athletic English missionaries, and was also apparent at Blantyre. In his handbook for European travellers in Africa Cross recommended *"an early morning ride before the bath"* as the best form of exercise.[157]

In December 1898, *the Aurora* published an article by Dr J. G. Mackay, a Scottish doctor who compared Central Africa with Madagascar, where he had previously worked. Mackay claimed that the Europeans in Madagascar took better care of their health and preferred to rest when suffering from fever rather than adopting the famous Central African approach of "working it off". In Madagascar, Mackay wrote, the latter treatment had generally resulted *"in*

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153 Stewart 1879, p. 292. The timetable on weekdays was 6.00-8.00 AM, work; 8.00-9.00, breakfast; 9.00-12.00 work; 12.00-3.00 PM dinner and rest; 3.00-5.00 work; 5.15 worship; 5.30. tea. Livingstone 1921, p. 102.

154 Stephen to Laws 2 April 1886. NLS, Acc. 9220 (3) (v).

155 Laws to the Governor of Nyasaland 27 February 1912. MNA/1/1/13 ,845.

156 Laws' diary entry for 15 October 1882. EUL, Gen. 561/3. Elmslie to Laws 6 June 1887. NLS, MS. 7890, 127. In 1883, Laws had used a "spray machine" to give vapour bath to Smith who had suffered form an acute attack of fever. Laws' diary entry for 25 June 1883. EUL, Gen. 561/3.

157 Cross 1897, p. 3; Hokkanen 2005; Mangan 1998; Mangan 1987a. Avoidance of overexertion on the move meant that Europeans travelled light, if possible. Henry Drummond described a typical traveller in the 1880s:*"The white man, as a rule, carries nothing except himself and a revolver, and possibly a double-awned umbrella, which, with a thick pith helmet makes sunstroke impossible."* Drummond 1888, pp. 102-103.

working off the patient instead of the disease".[158] Laws seems to have been careful when advocating "working off the fever", and both he and Elmslie condemned missionary colleagues who overexerted themselves.[159] By the turn of the century, the idea of "working off" the fever seems to have been largely discarded, but the danger of "overexertion" remained. Furthermore, the younger generation of Livingstonia missionaries increasingly embraced sport as healthy exertion.[160]

In the late 1920s, Laws described his view of the characteristics of the ideal missionary candidate. Men should be in sound physical condition, preferably not more than six feet tall, not outstanding athletes (for too much exercise could prove an athlete's undoing) and between twenty-one and thirty years of age. They should be used to plenty of exercise, able to sleep well and to eat plenty of plain food, to perspire freely and to be of *"regular methodical habits"*. Laws held "temperament" to be as important as physique, and it was important that candidates should be "steady" and not *"always up in the attics or down in the cellars...The hopeful, quiet, unpretentious, steady plodder is the man likely to live...Neither the very ardent, poetic nature nor the melancholic pessimist is likely to attain...satisfactory results."* Healthy missionaries should rise early, work hard in the early hours and have a siesta during the hottest time of the day, hunt and play games for exercise, and regularly sleep seven hours a night. Laws stressed that women candidates were particularly vulnerable in the tropics during their menstruation period, and emphasised that they should have extra hour of rest during periods, and take care of their diet and iron intake.[161]

Responses to casualties and pain

After Fletcher's sudden death in 1898, Laws wrote: *"We cannot understand God's purpose in removing Dr Fletcher within four months of his arrival at Bandawe. Yet we know He does nothing wrong…"*[162] This sense of surrendering to God's will and the feeling of Divine, if mysterious, Providence, was a typical missionary reaction to a colleague's death, in the field as well as in Scotland. This attitude

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158 *The Aurora* December 1898, p. 44.

159 In the Livingstonia Staff Record-Book, Laws wrote of the late Dr Henry, *"Dr Elmslie...said Dr Henry practically killed himself by overwork missionary & literary & by disregard of the laws of health – not culpable, but merely careless, he being indifferent whether he ate, or slept, or washed..."* Livingstonia Staff Record Book, NLS, Acc. 7548, D 72, 66.

160 In 1905, T.C. Young, a recently arrived mission accountant, wrote: *"My year has been wonderfully happy; my health fairly good...I'm not, I believe, a bad fever patient...From my youth up I have had a great fondness for my bed, and am less likely to aggravate a fever by over-exertion than my more energetic-perhaps more conscientious-brethren. But one misses the exercises of home – no football, no cricket, no golf. We've got together a fairly decent tennis court, however, and occasional games help to keep one's liver working, and also help one from occasional low spirits..."* Young 24 August 1905. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1905, p. 82.

161 Laws, undated address, MNA 47/LIM/4/2. This typed address can be dated to the mid-1920s. Cf. Collingham 2001, pp. 178-180 on theories of British women's constitutions in India.

162 Laws to Smith 10 March 1898. NLS, MS. 7881, 22.

served to reinforce the necessity of the mission. After so many had given their lives, it was all the more urgent for those left behind to carry on. If missionaries were hesitant to directly portray themselves as martyrs, those who died clearly were presented in this way. However, following cases of missionary deaths, there was also potential for controversy over whether and how such deaths could have been avoided, and particularly over the locations of the stations.[163]

God could not be blamed for deaths, but individual missionaries or the home authorities could, and it was sometimes debatable whether particular deaths had been "God's will" or results of errors of human judgement or carelessness. In early 1881, Simpson wrote from Scotland to Laws about the issue of moving the mission base from Cape Maclear:

> It is true that God's dealing with our Mission have been mysterious. But we know that He doeth all things wisely and well. I often think we have not acted in accordance with His will in settling down at Cape Maclear...some of the Committee members sayed [sic.] that it was all...ordered that these servants of God were taken away, and it would have seemed no matter where we have been stationed. But I am afraid that this is not the right view...

Simpson claimed that Laws' statements had been misinterpreted by some of the Committee members, and he believed that Laws would agree with him. Simpson had bluntly stated *"There is no use* [building] *our houses on the edge of the marsh and then praying to God to save us from malaria"*, and had been severely criticised by the Committee members.[164]

In 1886, the UMCA veteran Horace Waller wrote to Laws commenting generally on missionary losses in Central Africa: *"There is no doubt that...we must camp upon the inland hills. It is flying in the face of Providence to go on as we have been, we have no right to lose so many men."* Waller agreed with Laws' view that *"it seems as if Fever were the Devil's special piece of artillery"* and hoped that God would provide a better medication yet than quinine, which he called "a revelation". Waller reminded Laws how "poor old Livingstone", *"used to protest against settlement on the low ground and advocated the high land and then he waded about in mud and water till he died!"* Waller highlighted the contradictions between missionary theory and practice of healthy living in Africa.[165]

Laws appears to have balanced his views as a medical officer, seeing all lake shore stations as unhealthy, with the station head's priority of maintaining the mission at all costs, even though it would mean illness and fatalities. "The fever" was "the Devil's artillery", to be fought with careful hygienic regimes and God's quinine, not by a hasty withdrawal and change of stations. The

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163 Daly to Boxer 14 November 1905. NLS, MS. 7865, 465; After Mrs Cross's death at Mweniwanda's and just before his own death in January 1887, missionary carpenter Mackintosh regarded her death as *"another Livingstonia myster* [sic.]" and wrote that all Europeans at the station wondered how the news would be received at home. Mackintosh expected a recall but at the same time thought that *"if we are well and no special weakness about us I am sure it would be wrong to shirk our duty..."* Copy of Mackintosh (n.d., January 1887), presumably to Mr Duncan of Blantyre, copied posthumously by Laws. NLS, Acc. 9220 (1) (iv).

164 Simpson to Laws 6 January 1881. NLS, Acc. 9220 (1), (i).

165 Waller to Laws 8 April 1886. NLS, Acc. 9220 (3) (v).

pioneer missionaries' duty was to maintain their health, not only for personal survival, but also for the reputation of the mission and the chosen site. In 1884, Elmslie, then a recently-arrived recruit, wrote to Laws en route to Livingstonia: *"I am trying to be careful in every detail & hope to bring no false accusation on the evils of the climate by killing myself."*[166] Loss of life could lead to the loss of the station and ultimately to the loss of funding from Scotland for the entire mission.

The early missionaries were aware that there was a good chance they would die in the field. Doctors and nurses were acutely aware of this. After the deaths of Sutherland and Rollo, and at the time of Scott's departure Elmslie wrote to his mother: *"I try to do my duty & if I die it will be a glorious and welcome death."* However, he added: *"I am not gloomy or think a lot of death – I have no time to do it and it is not needed. Life is too earnest to look upon that which the Lord will make well in his own time."*[167]

After the initial shock of his good friend Sutherland's death, Elmslie wrote to Laws: *"I am realizing that it is a call to renewed energy and faithful work"*. Inspired by the sorrow of the Ngoni for Sutherland, for Elmslie, *"the thought of being regretted by these benighted people will inspire me so to live as that, if it is so ordered, I may have a place in their memories when I die."*[168] The missionary sacrifice for Africa would be complete when the Africans lamented and remembered those missionaries who had died.

Commitment to the possibility of dying in the field and perhaps becoming a missionary martyr, was very much part of the personality, identity, and being-in-the-world (subjectivity) of missionaries in general and particularly of those long-serving pioneer missionaries (including Laws and Elmslie) who had survived many illnesses and lost many colleagues. However, this may have been even more strongly the case for young unmarried missionaries such as Fletcher or young Elmslie. After a missionary had a family, priorities changed and the importance placed upon the health of the mission stations of the married missionaries testifies to this. If a missionary's wife or child died in the field, the husband could be accused of neglect. Conversely, controversial evacuation (as in the case of the Scott family) could provoke accusations of cowardice and abandonment of the mission. In these debates, a crucial issue was what the will of God was perceived to be.[169]

Laws believed that pain and suffering, both physical and mental, needed to be placed in the wider context of the grand objectives of the mission. The missionary "affections and desires" needed to be set against the main aim of the mission,[170] the advancement of God's Kingdom in Africa. This gave meaning to

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166 Elmslie to Laws 12 December 1884. NLS, Acc. 9220, (i), (ii).

167 Elmslie to his mother 7 January 1886. NLS, Acc. 9220 (1), (iv).

168 Elmslie to Laws 12 October 1885. NLS, Acc. 9220 (1) (iii).

169 Indirectly defending his family's departure in 1886 to Laws, Scott wrote that medical advice prevented them from returning to Livingstonia, and stressed that *"I trust we have been guided by God in this decision"*. Scott added, however, that he *"truly envy those who have strength and will to serve God in heathen lands"*, and ended his letter with best wishes to new recruits: *"...may God protect his servants in a treacherous climate, supporting them in sickness..."* Scott to Laws 2 August 1886. NLS, Acc. 9220 (1) (iv).

170 Sermon VIII, 25 February 1883. MNA 47/LIM/4/11.

pain, suffering and death. Laws and his wife stayed in Bandawe during the period 1886-90, but then sought a new base in the highlands. The Lawses and Elmslies, as well as other missionaries, sent their children home to be raised in Scotland: the mortality rates among European children in Central Africa was very high, and it was not acceptable for children to become martyrs for missionary cause.[171]

Prayer and health

When missionaries were seriously ill and felt as though they were dying, what was the significance of prayer? Did they surrender completely to God's will in a "Jobian attitude" which Horton claims was typical to modern Protestantism and to the nineteenth-century Protestant missionaries?[172] Or, did they intentionally hope that God would hear their prayers, spare them and let them be healed. Did missionaries hope to explain, predict and even control their life and their health in particular? The material studied does not provide simple answers, but it is clear that the missionaries often prayed in times of sickness and sometimes felt that their prayers had been answered.[173] During times of high mortality and illness, the missionaries frequently added the proviso "if I am spared" to any reference to the future in their letters. Prayer and healing, and the relationship between prayer and natural law were much-debated issues in the Victorian period, as highlighted by the controversy surrounding Queen Victoria's 1871 request for the clergy to pray for the cholera-stricken Prince Edward.[174] Despite potential tension between the two, it is highly significant that the pioneer missionaries and Laws in particular, brought with them both Western medical and Christian religious responses to illness, in theory, practice, rhetoric and symbol.

It is safe to say that in sickness and in recovery, if missionaries felt God's presence or mercy, their physical well-being was understood to have improved as a result of the experience. It is perhaps too crude to say that when medicine failed, religion took over. The two should rather be seen as intertwined, but religion was the final consolation in times of crisis. In his sermon in 1883, Laws stressed that reason and faith go together, but *"Where reason stops short or falls faith takes up the thread"*.[175] The missionary doctors stressed the importance of the moral and spiritual state of their patients believing that it could be a crucial factor in their survival. However, a "false" religious experience could be "unhealthy", too "emotional", and psychologically disruptive.

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171 See Prentice, in *The Record,* April 1922, p. 122.

172 Horton 1993, p. 155.

173 For example, Laws prayed for his seriously ill baby daughter that "she might be spared" and she recovered. Livingstone 1921, p. 226.

174 Opp 2000, pp. 25-26.

175 Sermon VIII, 18 February 1883. MNA 47/LIM/4/11.

6 EARLY THERAPEUTIC ENCOUNTERS, EXCHANGES AND DIALOGUES, 1875 – C. 1900

6.1 Displays of benevolence and power: medicine as gift, surgery as performance

Medical practice and therapy management at Cape Maclear

The pioneer party started to offer medical aid to Africans immediately after their arrival at the lake. A key group of patients at Cape Maclear between 1875 and 1881 were the mission associates and dependants. The station had a growing African population; by March 1877, around sixty Africans lived in Cape Maclear. William Black observed that some Africans had originally sought medical treatment and remained at the station after their recovery. A therapeutic relationship could thus be the beginning of long-term missionary interaction with those who settled at the mission. An important group of African settlers was the thirty-strong household of Chimlolo, a Yao from the Shire Highlands, who became a close associate of Laws. Laws treated several members of Chimlolo's family. Another headman in Cape Maclear, Mpasa, was according to Laws suffering from leprosy,[1] a disease which could contribute to a patient's marginalisation in society.

Laws wrote in his medical report for 1876-77:

> The good we have been able to do the bodies of the people, they can readily appreciate and they are thus the more ready, while at the station, to listen to the great truths we proclaim, and on returning to their villages they carry with them a good

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1 Black to Smith 3 March 1877. NLS, MS. 7876, 176; Livingstone 1921, p. 92; Daily Journal of Livingstonia Mission, entries for June and September to October 1880, and February 1881, case 110. MNA 47/LIM/10/2. Chimlolo had been living with the ill-fated Universities' Mission, and wanted to resettle with the new Europeans. One of patients from Chimlolo's village was "Mrs Mlolo" who was treated by Laws on several occasions in September and October 1880.

> report of our transactions with those coming to us and open up a way for our reception among them…[2]

This summarises a central idea in nineteenth-century medical missionary theory: the successful treatment of the heathen body by a missionary could transcend cultural and linguistic barriers. The treatment of a patient gave the missionary healer an opportunity to establish a communicative relationship, allowing the missionary healer to convey his Christian message more easily to the patient. No instant conversion was expected, but missionaries hoped to establish a lasting relationship of communication, and encourage a continuing feeling of gratitude. The healed patients transmitted news of the benevolent missionaries to their own communities, which would be approached in due course. As Butchart has pointed out, the transformation of patients into publicists was an essential part of nineteenth-century medical mission activity.[3]

In December 1879, Jane Waterston wrote in a positive tone to Stewart about her medical practice, after she had taken over much of the increasing practice among the Africans: *"... the medical work is increasing so fast that I am kept very busy… Saturday I had twelve patients and paid nine visits, three of these by boat."* Waterston had been at Cape Maclear for just over a month, and patients travelled from some distance to be treated by her. One chief had left his sick baby in her care. She mentioned that she had become "great friends" with Chimlolo, whose eye she had treated. Local medical culture clearly accepted woman practitioners more easily than was the case in Victorian Britain. Some patients who had travelled a considerable distance were not easily turned away. On occasion, patients could even prevent the doctor leaving them. While she was staying in Blantyre, Waterston had treated Kumalombe, an "old head man" who had been shot in the leg. She learned afterwards that she could not get carriers to take her to Livingstonia because Kumalombe had ordered that none should be made available to her.[4]

Laws' first medical report raised one of the central issues in early mission medical practice: how to feed and nurse those patients who needed to stay in the station.[5] In practice, the missionaries often had to leave patients to "their own resources", which meant that they had to rely upon relatives or friends – the therapy management group – to support them. However, the missionaries also met lone ill individuals such as runaway slaves, refugees and orphans, and treating them also meant feeding them. After their recovery, these patients could "pay" for their treatment by working for the missionaries. This was one way of becoming part of the mission community. For the mission dependants in Cape Maclear, who formed the nucleus of the future Christian converts, the missionaries became therapy managers. Membership of the mission community offered vital new social and economic opportunities to those without functional

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2 Medical Report for 1876-1877, Cape Maclear Journal 1875-1876, NLS, MS. 7908.

3 Butchart 1998, pp. 78-79.

4 Waterston to Stewart 29 December 1879. LJEW, pp. 165-166, 176. Cf. Comaroff and Comaroff 1997, pp. 340-341.

5 Medical Report for 1876-1877, Cape Maclear Journal 1875-1876, NLS, MS. 7908.

relationships. As Iliffe has noted, dependence upon a powerful leader or a group was a common response to famine and poverty in nineteenth-century Malawi, as were attempts to establish kinship ties with the wealthy. W.P. Johnson translated the English word "freeman" into chiYao using a phrase meaning "of the family". In chiMang'anja/chiChewa, *umphawi,* translated in D.C. Scott's *Dictionary* (1892) as "misery, slavery, friendlessness", described a state of extreme poverty into which many displaced individuals and small groups had fallen during the nineteenth-century invasions and upheavals. To be free, a person had to be part of a family, and for freed slaves and orphans, the mission community could function as family and kin group, and therapy management group. As Feierman has noted, such social changes strongly influence the individual experience of healing.[6] Some of the mission dependants – including the mission pupils, personal servants and their families – moved with the missionaries to Bandawe in 1881, and remained within medical reach of the mission. In 1882, when Laws listed his patients as "men, women, boys, girls", almost all the "boys" treated were from Livingstonia.[7]

For those who stayed at Cape Maclear, however, missionary medicine once again became a remote resource. After the missionary departure, Cape jurisdiction was left in the hands of the headmen Chimlolo, Mpasa, and Kabanda. Laws left them with instructions that the poison ordeal must be discarded and "no *mfiti* to be recognized", except, as Laws added humorously, *moa* (beer). However, McCracken has noted that in the 1880s both Chimlolo and Mpasa resorted to the *mwavi* poison ordeal in order to settle disputes. There is little doubt that indigenous practitioners would have resumed their medical monopoly in the area after Laws' departure.[8]

Early communication

The early contacts between the Scots and local leaders were made possible by the mediating work of the African members of the mission. The pioneer party included four former slaves: three Yao and one Mang'anja. They had been freed in 1861 by UMCA missionaries and, after the collapse of the Universities' mission, had moved to Cape Town. As intermediaries, men such as Thomas Boquito and Samuel Sambani were invaluable, being experienced travellers with knowledge of local languages and European customs. In all probability, these intermediaries promoted Laws as a healer to the local people and

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6 Feierman 1985, pp. 84-85; Good 2004, p. 254; Iliffe 1984, p. 252; McIntosh 1993, p. 27.

7 Daily Journal of Livingstonia Mission, entries for 1882. MNA 47/LIM/10/2.

8 Livingstone 1921, p. 188; McCracken 2000, pp. 82-86. While people from both Chimlolo's and Mpasa's were frequently mentioned as attending the dispensary in April and December 1880 and March 1881 there are only a few entries from Kabanda's, who was reputedly an "old witch doctor". Kabanda's household may have been smaller and/or more distant than the others, but it is also possible that Kabanda was a healer himself, and treated his own people. Daily Journal of Livingstonia Mission, entries for April and December 1880 and March 1881. MNA 47/LIM/10/2.

translated for him. More former slaves arrived with the second mission party in 1876, along with four Xhosa evangelists from Lovedale. Of these evangelists, William Koyi (1846-1886) became a particularly significant figure at Livingstonia.[9]

The pioneer doctors (Laws, Elmslie, Cross and Henry) all undertook linguistic studies and translations. Henry's linguistic skills were particularly admired by other missionaries. Laws focused on chiMang'anja, which he considered would be the most effective *lingua franca* for the lake region, while Elmslie's work was done in chiNgoni and Tumbuka. It is difficult to assess how fluent Laws, who held that he personally was "no linguist", became in Tumbuka, the most common language in Northern Malawi which eventually became the official vernacular in the mission. After the move to Bandawe, the missionaries' ability to communicate clearly suffered somewhat, although Laws had compiled a vocabulary of "500 most useful words" in chiTonga before the move.[10] MacAlpine, who was critical of the early missionaries' and particularly Laws' linguistic skills, later claimed that until the 1890s the preaching by missionaries in chiMang'anja and the early translation of St. Mark's Gospel into chiTonga were a source of amusement to the people in Bandawe.[11]

Medicine and diplomacy

Among the first Africans to be advised and treated by Laws were chiefs and leading families, as part of the missionary diplomacy advocated by Livingstone and adopted by the Free Church authorities. The instructions given to the pioneer party stressed the need to avoid conflict and prohibited the active use of force. Instead, the value of "simple acts of kindness and courtesy" was emphasised. Offering medicine was an essential and important act of kindness. Two days after the missionaries had arrived at the lake, they sailed to Nkhotakhota, the main trading centre on the western shore, where there was a great demand for medicine. Jumbe, the Arab leader of the town was among those who consulted Laws. Laws believed that Jumbe, like most people asking for medicine, was probably suffering from syphilis and promised to alleviate

9 McCracken 2000, pp. 78-79; Thompson 1995, p. 40. Of the first group of Europeans, only Young had been in the area previously, and his proficiency in local languages was questionable. See Livingstone 1921, pp. 84-85.

10 The English-Nyanja dictionary Laws published in 1894 reveals some of the words and phrases missionary doctors used at that time. For example, "he amended my pain with medicine – *Wapepuza kupweteka kwnaga ndi mankwala*", "Amend in health – to reform by quitting bad habits – *ku tembenuka; ku leka.*" Terms such as abscess, afterbirth, amputate, artery, blisters, body, bowels, colic, contagion (contagion of smallpox – *Uliri wa ntomba*), cure, cut and smallpox were all listed in this dictionary. Laws 1894; Livingstone 1921, p. 182; McIntosh 1993, pp. 81-82.

11 EUL, MacAlpine Papers, MS. 3086.2, 3086,4. According to MacAlpine, the Europeans' chiMang'anja was called "Chizungu" (white speech) and was widely criticised without the missionaries' knowledge.

his pain, but believed that only *"continuous surgical treatment"* could offer any hope of a cure.[12]

Anaesthetic surgery as a display of power

During his first visit to Mponda's, Laws met Koomponjeera, who had a "cystic tumour" above his left eye. Laws had offered to remove the cyst surgically, but it was only during the missionaries' second visit, when they were preparing to take one of the chief's wives and another patient who had requested medicine for worms to the station for treatment, that Koomponjeera agreed to the operation and came to the station with two companions. Laws performed the surgery on 2 March 1876 in the presence of three witnesses, allowing Laws to demonstrate the power of Western medicine. This power was dramatically displayed through his use of chloroform to anaesthetise the patient. Laws believed that the success of the operation was essential to the future of the mission.[13] Consequently, he must have been convinced that the chances of a successful outcome were sufficiently high to warrant undertaking the operation.

Laws deemed the operation to be a success, and recalled a year later that: *"The effects of chloroform quite took them by surprise, and as they saw the patient quietly sleeping while the knife was being used, and afterwards heard him declare he felt no pain, they spoke of him having been dead."* Laws claimed that chloroform "by itself" established a distinction between the "English doctor" and "native dealers in charms".[14]

Did chloroform really establish mission medicine as a distinct and superior form of medical art in African perceptions? The effects of chloroform were almost instant, and so the anaesthetic could be regarded as powerful form of "magical" medicine. Laws' description of the operation suggests that some of the witnesses thought, at least initially, that Laws first killed the patient with chloroform, then cut his tumour away with a knife, and finally brought the patient back to life.[15]

This pattern bears a resemblance to what, according to van Breugel, is regarded among the Chewa to be the central activities of the cannibalistic *mfwiti yeniyeni,* "true witch". First the *mfwiti* raises the deceased from the grave using

12 Cape Maclear Journal entry for 12 October 1875. NLS, MS. 7908; McIntosh 1993, p. 26; Gelfand 1957, pp. 5-6.

13 Cape Maclear Journal entries for 1-2 March, 1876. NLS, MS. 7908; *FCSMR* August 1876, p. 192; Livingstone 1921, pp. 92-96.

14 Medical Report for 1876-1877. NLS, MS. 7908. The eye-witnesses apparently did not include Mponda's wife, who could have been a particularly influential messenger to the chief, but she probably heard about it immediately as she was on the station. Livingstone 1921, pp. 92-96. The missionaries met this woman again in Mponda's village later in 1876, and Young wrote: *"We had a chat with her about things in general and her own health in particular, but she wisely told us that it would not do for her to let out court secret. She is far superior to her bloated sot of a spouse."* Young 1877, pp. 162-163.

15 Medical Report for 1876-1877. NLS, MS. 7908; Livingstone 1921, pp. 92-96; Cf. *Annual Report for 1902*, pp. 38-40.

specific *mankhwala*, then wakens and fattens them with another *mankhwala*, and finally kills them with the third *mankhwala*, proceeding to remove the flesh and eat it. Like *mfwiti*, Laws also cut away human flesh using his surgeon's knife. He operated on a dining table – unwittingly creating a further association between surgery, dining and cannibalism.[16] According to such a reading, Laws appears if not as a witch, at least a medicine man or magician armed with new, powerful but ambiguous resources, instead of an easily approachable doctor using safe medicines. If it highlighted a distinction between the European doctor and a local *sing'anga,* surgery under chloroform was most likely to have placed Laws in the category of medicine men with potentially dangerous knowledge.[17]

Koomponjeera remained in Cape Maclear for twelve days. Mponda's wife, who had been treated for "rheumatic pains", seemed to be recovering well after some days at the station. The outcome of the treatments, then, was some personal fame for Laws as well as for the mission – although this fame may have been more sinister than the missionaries realised – and a personal healer-client relationship with Mponda and his dependants. However, the operation did not result in a large number of further requests for surgery, which missionaries would have had to refuse anyway due to lack of resources and time. Without a hospital or a fixed arrangement for nursing or feeding patients, the missionaries had to be careful when selecting their patients. Furthermore, Laws only wanted to undertake operations with a high probability of a successful outcome. A well-publicised failure had the potential to undermine the confidence engendered by all the previous successes.[18]

Although Laws did not become Mponda's court doctor, he continued to treat the chief and his people for minor ailments, and the fact that the dying Mponda requested medical treatments from Laws in 1885 showed that the doctor had managed to establish some status as a medical specialist in the chief's eyes. Laws' patient book for 1880-82 records only a few patients who came from Mponda's.[19]

In missionary propaganda as well as older mission historiography, Laws' first operations using chloroform were lauded as unqualified successes which increased the doctor's prestige, to the extent that people from near and far (and, in particular, women) would travel to the mission to receive his treatment. In

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16 van Breugel 2001, pp. 213-214. On dining and surgery, see Hunt 1999, pp. 117-123 and *passim.*

17 Such knowledge can be thought of as belonging to a third category in African "three-value logic": not as "false" or "true" but as being "outside true and false", a "red" sphere of magic and medicines marked by their unpredictability. Western medicine in Africa has often been seen to belong to this category. Jacobson-Widding 1989, pp. 17-22.

18 Cape Maclear Journal entry for 5-14 March 1876. NLS, MS. 7908; Black to Smith 3 March 1877. NLS, MS. 7876, 176; Medical Report for 1876-1877. NLS, MS. 7908.

19 In October and November 1880, a woman named Akuluveja came to Cape Maclear from Mponda's, after her husband had approached Laws a week earlier. She remained at the station for almost a month, treated for *"Cystisis & al."* Daily Journal of the Livingstonia Mission, entries for October and November 1880. MNA 47/LIM/10/2; McCracken 2000, p. 71.

1881, it was claimed that *"Excisions of tumours have been most numerous. Many have come from great distances for operations and advice"*. In addition, missionaries frequently received requests for "medicines" to protect against wild beasts as well as human enemies. Laws was, according to W.P. Livingstone, "deeply impressed with the power which his medical knowledge gave him over the natives and the opportunity it afforded of commending to them the message of the Divine healer". During subsequent operations using chloroform, Africans gathered around the building watching the doctor "calmly cutting away at a man's body while his assistant mopped up the blood." The people spoke of anaesthetisation as "dying".[20]

It is argued here that the operations using chloroform resulted in some fame for Laws and the mission, not simply as superb healer but rather as someone to be wary of. Furthermore, although occasional cases of individual patients who had travelled long distances to Livingstonia were recorded in Laws' 1880-1882 dispensary book, the vast majority of patients who visited the mission dispensary came from the immediate neighbourhood and suffered from minor ailments. Laws' reputation as a medicine man (of whatever hue) may have been largely due to his prudence when deciding which operations to attempt and which to decline, as he managed to successfully avoid any catastrophic failures during his early surgery at Livingstonia.[21] The missionary doctors' position as the last resort, in general only approached after all other medical specialists had been consulted, was not particularly gratifying to them. Laws' special skills, although dramatically demonstrated through his use of chloroform, remained ambiguous in comparison with the local therapeutic alternatives.

A display of the power of chloroform could inspire not only awe in those who witnessed the operation, but also fear. By poisoning leopards with arsenic at Mponda's request, the missionaries had publicly demonstrated that they possessed lethal medicines. Poison, or lethal medicine, was an ambiguous substance: depending on its use, it could be accepted and useful, or terrible and criminal, in both European and African contexts. Arsenic and strychnine, both powerful tonics in the mission dispensary, were used by missionaries to poison lions and leopards and were occasionally provided to chiefs and headmen.[22]

In Central Africa, poisoning could belong to the sphere of what Europeans translated as "witchcraft". Body-cutting, witchcraft and cannibalism were all closely connected within Southern and Central African cultures and this would have influenced the ways in which missionary surgery and medicine were first perceived, interpreted and communicated across the region. Tales of European cannibalism circulated in the lake area in the 1870s and early 1880s. According to some rumours, the salt meats in casks were in fact the bodies of children lured to Cape Maclear, who had been killed and then preserved. Stories which

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20 *Livingstonia mission...a six years' history and appeal.* Edinburgh 1881; Laws 1934, p. 64; Livingstone 1921, pp. 92-102, 140; Hanna 1950, p. 17; McIntosh 1993, p. 40; Young 1877, p. 155.

21 Daily Journal of the Livingstonia Mission. MNA 47/LIM/10/2.

22 Laws' diary entries for 5-6 June 1880. EUL Gen. 561/2; Livingstone 1921, p. 289.

portrayed Europeans as cannibals had been told by the Swahili traders in the region since at least the late 1860s.[23] In this context Laws' surgical operations could be interpreted, and retold through stories and rumours, and could as easily be horror stories as tales of uncritical praise for the new healer.[24]

War medicines

The use of medicines during wartime, to defeat one's enemies, belonged to the legitimate craft of war, and to the sphere of politics in Central Africa. Missionaries discovered during the first years of the mission that they were frequently seen as a potential source of war medicines. In the violent circumstances of the 1870s and 1880s, the leaders of the region looked towards missionaries as potential allies who could provide access to new skills and powers. It was also deemed to be important to ensure that others did not establish an exclusive alliance with the missionaries. Whether or not the Europeans actually provided "war medicines", some African leaders claimed that they had received such medicines. By claiming an alliance with the whites, and boasting about the power of their medicines, the leaders used powerful rumour as a propaganda tool. It was in the interests of the propagandists to exaggerate European power, and by extension their own. This was the case with the Makololo in 1876, who, following the peaceful meeting of E.D. Young with an Ngoni war party claimed that an alliance with the all-powerful Europeans prevented the Ngoni from attacking them.[25]

When the missionaries first circumnavigated the Lake Malawi in 1877, chiefs on the western shore repeatedly requested war medicines to use against the Ngoni, and would not accept the refusals of Stewart and Laws. At the lagoon of Kambwe (forty miles north of Deep Bay), chief Kalonga gave them a young bull and a tusk of ivory in exchange for medicine which would increase the bravery of his warriors. When informed that the doctors did not have such substances, he was convinced that the whites kept the medicine for themselves. When Stewart met with the leading lakeshore Tonga chief Mankhambira, "*The conversation always converged to the point whether we would give him mankwala... to destroy his enemies*". After defeating the Ngoni in a battle at Chintheche, Mankhambira declared that the secret of his victory was the use of war

23 Livingstone 1921, p. 179; Young 1877, p. 161. According to Young, in the 1860s, the Swahili had spread rumours of "English eating black people" to terrify the people, with great effect, although he believed these stories were declining by the late 1870s. Similar *tokwakwa* tales were told in twentieth-century Congo (as well as in Central and East Africa generally), where white doctors were suspected of injecting people and fattening them up to be killed, made into tinned food and eaten. Hunt 1999, pp. 182-185. See also Landau 1996; White 2000.

24 In the Malawi region, human blood or organs were used in war medicines at least in Mponda's stockade. In 1890, the Catholic missionaries there witnessed how an Ngoni prisoner had his throat slit and his heart torn out. A medicine man burned the heart to ashes and mixed it with flour to prepare a war medicine designed to protect warriors from enemy projectiles. Linden 1974, p. 27.

25 Young 1877.

medicines received from the whites, which reputedly enraged the Ngoni. Following the settlement of the missionaries in Bandawe, some Tonga anticipated a battle between the missionaries led by Laws, the *sing'anga,* and the Ngoni, and an eventual Ngoni defeat.[26]

The rumoured power of the Tonga seemed to have some effect. In December 1878, when the Northern Ngoni paramount M'mbelwa first met representatives of Livingstonia (Koyi and Riddel), he wanted to ensure that the Europeans would not provide Mankhambira with war medicines.[27] In the late 1870s at least, it was widely believed that the Scots not only had efficient firearms, but also possessed potential medical powers that could be used in war. Furthermore, such beliefs and rumours were actively propagated by those groups fighting the Ngoni, and were, to some extent, believed. The missionaries' use of medicine in diplomacy, their poisoning of wild beasts and the display of power through surgery and chloroform in particular, reinforced the image of Europeans as "medicine men" with dangerous and potentially lethal knowledge and powers.

It is possible that these beliefs occasionally prevented attacks against the missionaries. No Livingstonia missionary was ever killed violently. When the missionaries anticipated a Ngoni attack on the station in Njuyu in 1886, Elmslie buried his medicines and instruments secretly at night, in preparation for evacuation. However, it seems that he was seen and his nocturnal activities had become common knowledge; in uTonga some time later Laws overheard people talking about "the white man hiding his instruments". In Central African medical culture defensive medicines were commonly buried to protect a house, garden or property. An intruder walking over these medicines could suffer illness or death. In this context, Elmslie's actions could have been interpreted as defensive, and may have served as a deterrent against those contemplating an attack on the station.[28]

It is difficult to fully assess and easy to overestimate the importance of medical practice and surgical operations in shaping local leaders' and groups' perceptions of the Livingstonia Mission. It should be borne in mind that the high rates of sickness and number of deaths among the missionaries themselves (at least until the turn of the century) would provide ample empirical evidence for those questioning the efficacy of mission medicine. During their visit to uNgoni to attend negotiations with the Ngoni leadership in April 1882, both Laws and Hannington were seriously ill. Both suffered from fever and vomiting, and Hannington almost died when his heart stopped. It is significant that M'mbelwa and the Ngoni commonly called Laws *Lobarti*, a version of his first name, not "doctor", or "medicine man". Furthermore, the Ngoni chiefs were often medicine men of some repute themselves, and recognising Laws as a

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26 Livingstone 1921, pp. 130, 153, 192; Stewart 1879.

27 Thompson 1995, p. 32.

28 Livingstone 1921, p. 231; Scott 1897, pp. 315-316; Mackenzie 1925, 260-262; Young 1931.

man who possessed particularly potent medicines did not necessarily mean anything more than acknowledging him as the chief of the Europeans.[29]

Medicine shows and performances

In his travel narrative from the north end of Lake Malawi during 1883, Henry Drummond described the spectacular European display of instruments and inventions as an essential means of securing authority among Africans. In the tradition of travellers' tales, he claimed that his use of burning glass impressed the people, whom he believed regarded him as a "mighty spirit bringing fire from the sun". Drummond claimed that

> Why a white man, alone and unprotected, can wander among these savage people without any risk of murder or robbery... it is his moral power, his education, his civilisation. To the African the white man is a supreme being. His commonest acts are miracles; his clothes, his guns, his cooking utensils are supernatural... I asked my men..."Why do you not kill me and take my guns and clothes and beads?" "Oh," they replied, "we would never kill a spirit"[30]

However, in addition to this colonial delusion of grandeur and fantasy of the demi-godlike authority bestowed upon Europeans, Drummond also provided a more sobering account of African reactions to European novelties when he noted that, in general, none of his instruments excited any interest. Furthermore, he described how he experienced the recurring shows of European wonders to local chiefs, in which he had to button his coat, strike a match, or set fire to bark-cloth with burning glass, as "humbling performances". He had to perform these shows three or four times a day.[31]

Pioneer Europeans in Central Africa could have a variety of images: traders, hunters, employers, medicine-men, spiritual specialists, entertaining performers, curiosities and in extreme cases, spirits and cannibals. Some people were interested in them; some were suspicious, awed or frightened; while many were neither impressed nor interested. Pragmatic and economic concerns rather than curiosity or awe of "exotic" objects or "magical" powers motivated long-term interest in the Europeans. As McCracken has noted, due to extensive trade and travel connections between the Malawi region and the coast, many Malawians had known or at least heard of Europeans (including the British) before the missionaries arrived. It would be a gross simplification to claim that Europeans were universally held to be awe-inspiring supernatural creatures.[32]

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29 In contrast, in uTonga, where Laws practiced medicine regularly, he was called *Dotolozi,* or *Sing'anga wamkura,* the "great healer". Livingstone 1921, pp. 198-204. Livingstone quotes here two anonymous Tonga converts, a school inspector and a pastor, who were pupils at Bandawe in the 1880s; Mkandawire 1971/1972. M'mbelwa, for example, was known to possess powerful medicines.

30 Drummond 1888, pp. 105-106.

31 Ibid., pp. 103-104.

32 Ibid.; McCracken 2000, pp. 41-42. Cf. Fabian 2000, pp. 102-114, 141-144. In 1887, the explorer Becker argued that the days when Europeans were regarded supernatural beings in East Africa were over: *"They have seen us suffer, as they do, from hunger, thirst,*

What mattered in the long-run was their relative wealth, their offers of employment and their potential to provide access to new material and non-material resources.

Medicine was one resource among many, and was not only limited to medically qualified Europeans. Europeans could, on occasion, impress the chiefs and headmen with spectacular displays of medical power, which could be regarded as alternative performances of power to violence[33] but the real sovereign power of life and death lay with African authorities, and pioneer Europeans were dependant upon their tolerance. However, in the first mission settlements at Livingstonia and Blantyre, a number of Africans came under direct missionary rule for a short period.

Medicine and punishment

Jane Waterston's resignation in 1879 was partly due to her conflicts with Laws (as noted previously) but she also cited her disillusionment and disappointment with the missionaries' behaviour towards Africans. At this point, the missionaries had resorted to the use of corporal punishments, in both missions. Floggings were commonplace and in Blantyre one man was executed whilst another was flogged to death.[34]

In the standard nineteenth-century British military procedure for flogging, it was the duty of the medical officer to supervise the punishment and ensure that the flogged man could survive the ordeal. This procedure was apparently discarded in the fatal flogging case at Blantyre. Macklin, the doctor, was not present, but he later claimed that the flogged carrier – who was reportedly given two hundred and seventy-five lashes with a hide whip for losing a box of tea – had died of heart failure. The news of these atrocities (the flogged man was widely believed to have been innocent) caused a scandal in Britain, and both Blantyre and Livingstonia were ordered to cease their temporal activities by 1881.[35]

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and fever in spite of all our riches... [most Africans]*... know that we are weak mortals, less resistant than they to the surprises of the climate, and that the only advantages we have are our industrial products and the superiority of our firearms."* Quoted in Fabian 2000, p. 143.

33 Cf. Butchart 1998; Fabian 2000, p.145 on the violence of European explorers as performances.

34 Waterston to Stewart 4 October 1879. LJEW, pp. 155-156; Report on the Blantyre Mission Case, NLS, MS. 7904; Chirnside 1880; Fry 2001, pp. 161-162; McCracken 2000, pp. 82-85, 97-98.

35 *Report on the Blantyre Mission Case*, NLS, MS. 7904; Chirnside 1880, pp. 20-22; McCracken 2000, pp. 98-103. Flogging in the British armed forces had been restricted in 1859, and it was completely abolished in 1881. McIntosh 1993, pp. 60-61. In 1879, Horace Waller had advocated flogging as punishment to be used by the missionaries in Central Africa, "*as it has from time immemorial in our public schools*". Waller stressed the need for medical supervision because of *"a singular idiosyncracy in the native capacity for standing pain"*. Waller to Macrae 27 December 1879. (Printed for private circulation). NLS, MS. 7904. In his defence of the Blantyre missionaries, Alexander Riddel emphasised that the only floggings he had witnessed were performed under the supervision of a surgeon. Riddel 1880.

According to Laws' biographer, Laws personally witnessed only one flogging, which he supervised at Cape Maclear. The flogged man had reportedly "stolen", presumably raped, a mission school girl. Laws led the party which released the girl, arrested and imprisoned the man, and burned his hut. Laws then called upon the man's chief and the headmen to determine his punishment, which was set at twenty lashes. Laws halted the public lashing at thirteen strokes, applied ointment to the man's back and released him the following day.[36] The reliability of Laws' hagiographic biography can be, to some extent, called into question here. However, there is no reason to doubt the practice of a medical officer standing by and administering first aid to the flogged man. To onlookers, it would have been clear who was in charge of the punishment. It is notable that the floggings in Livingstonia, with this exception, apparently took place while Laws was not present, under Stewart CE, Miller and under Allan Simpson at the Bandawe observatory station.[37] Thus, most floggings were carried out without any medical supervision.

Laws held flogging to be a "sickening thing", and was happy to end the practice, although he believed that it had "done good" at Cape Maclear.[38] According to his biographer, he judged minor cases with "grim, even grotesque humour" and resorted to the dispensary to mete out unconventional punishments. In order to "cure" those pupils who appeared to be the "worse of beer", he administered a dose of mustard and water to each boy in the presence of the entire school. After the move to Bandawe, Laws caught a boy stealing from the mission store. He took him back to the store, and "showed him a mortar and pestle, into which he slipped some chemicals from various bottles." He ordered the boy to stir the mixture, which resulted in a small explosion. He then lectured the frightened youngster, "take warning. You don't know what will happen if you will enter this store". Chemical tricks were sometimes used to generate fear of anti-theft medicine. Such medicines were the stock trade of many medical specialists in the Malawi region. Laws summoned "delinquents"

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36 Livingstone 1921, pp. 136-139. McIntosh (1993, p. 60) gives the original number of lashes to be thirty. Stephen to Smith 12 March 1881, quoting McFadyen, gives a slightly different description, with the jury of missionaries and Africans setting the number of lashes to "about 24", to be given by four or five artisan missionaries, and mentions that Laws "held the man's pulse during the punishment to see that nothing would go wrong." However, McFadyen claimed he had not personally witnessed the event. NLS, MS. 7872, 184.

37 When Allan Simpson, who was involved in many floggings at Bandawe, was questioned at home in 1881, he was asked of one case: "Why was Ropa flogged and by whose authority?" Simpson answered, "By Dr Laws' authority and for fornication &c." Simpson evaded the important question of who first initiated the system of flogging at Livingstonia. Simpson to Laws, n.d. NLS, Acc. 9220, (1), (i). Simpson was censured for his involvement in floggings and was not re-employed by the mission but joined the ALC in 1882; McIntosh 1993, p. 60. There were accusations from the Established Church that corporeal punishments were brought to Livingstonia from Blantyre, which the Free Church denied. *Free Church of Scotland Statement by Foreign Missions and Livingstonia Committees...1880-1881.*

38 Extract of Laws to Smith 18 March 1880, in Minute-Book of the Sub-Committee of the Livingstonia Mission, Minute of meeting 2 June 1880. NLS, MS. 7912

to him with a seal of red wax, which, according to Livingstone, was commonly "imagined to be solidified blood" and his summons were never disobeyed.[39]

Laws' curious combination of medicine, justice and punishment would be easy to dismiss as a bizarre, but marginal, case of colonial humour. However, what is significant here is the way in which Laws became a doctor, an arbiter and a judge, and the role that medicine, *mankhwala*, played in his judicial behaviour. Indigenous Central African medical practitioners were often also arbiters of disputes, and *mankhwala* had many functions, including use in court proceedings.[40] It can be argued that Laws adopted and combined the local roles of a medicine man and a chief capable of wielding judicial powers partly intentionally but was unaware of all the possible ramifications of his behaviour. Laws' use of medicines and his perceived medical powers were an essential part of his image and roles, and the reputation he established through performing chloroform operations gave him an authority based on fear. Those people who received a seal of solidified blood were summoned by a man who reputedly killed people with his *mankhwala*, cut their flesh on his dining table and awoken them again, and about whom even more sinister rumours circulated. Such a figure was not to be taken lightly, but his authority depended largely on belief, myth and story and is difficult to assess in retrospect.

The Bible as medicine

The missionaries unwittingly provided grounds for the interpretation of the Bible as a form of white man's "medicine" with charm-like properties. In December 1878, Alexander Riddel, the mission agriculturist, and William Koyi were the first Livingstonia missionaries to meet M'mbelwa, the northern Ngoni paramount. They stated that they had come with a message from God, and while showing the paramount a Bible, Riddel claimed that it was what had made the whites' nation "rich and powerful". In meeting with Laws in 1878, Chikuse, paramount of the southern Ngoni, asked for Laws' Bible. Laws refused, suspecting that the chief would use it as a "charm".[41]

As Cairns has noted, the nineteenth-century missionaries in Central Africa were generally unwilling to separate Christianity from Western culture, believing that social benefits, prosperity and power all stemmed from the Christian religion. In their world-view, the superiority of the West was unquestionable, and it was difficult, and almost contradictory, for the missionary to isolate the Word from Western culture. However, for Laws, it was essential that the social and material benefits of Christianity should not be regarded as coming directly from Bible as a medical/magical object. In 1882,

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39 Livingstone 1921, pp. 138-139, 190; Young 1931, pp. 111-112.

40 Scott 1897, pp. 315-316; Young 1931; Lacey, A.T: "Notes on a recent anti-witchcraft movement in Nyasaland". A dissertation... for the Diploma of Anthropology at the University of Cambridge, May 1934, Rhodes House, MSS. Afr.r., 72, pp. 91-93 and *passim*.

41 McIntosh 1993, pp. 65, 150.

Laws, interpreted by Koyi, was at pains to make it clear to the Ngoni elite led by Mtwalo that the Bible was not a “charm”, but that a nation or an individual would prosper if they would received and obeyed the Word of God. However, he also added that if a nation abandoned the Word, it would eventually “sink” and be destroyed, *“God’s curse laying upon it”*.[42] In the early meetings, Laws stressed that the missionaries wished to tell the Ngoni what was in the Bible and to teach their children how to read it, to give medicine to the sick, and be the “friends and helpers of all”.[43]

Laws aimed to create a clear distinction between the teachings of the Bible and medical practice, and the Bible as God’s Word and the literal interpretation of the Bible as a source of wealth, prosperity and health. How far he succeeded is difficult to assess, and it is interesting to note that he also introduced the idea of “God’s curse” to those who would not heed the Word. In the late 1880s and early 1890s, many Africans associated with the mission were willing to acquire a copy of the Gospel or a portion of Scripture, as they became available, and paid for them from their limited wages. However, the Protestants were not the first group in the Lake Malawi region to possess sacred writings. Swahili traders had brought with them texts from the Koran, and these were commonly used for protective and healing purposes, as “charms” in Western classification, but fell within the broad scope of “medicines” in Central African thought. According to Marwick, among the Chewa of Northern Rhodesia in the mid-twentieth century there was a belief that Christians used the Bible as a means of divination, and that taking the sacraments was a Christian form of the poison ordeal, cleansing the community from sorcery.[44] Regardless of missionary intentions to control the meaning and interpretations of the Word and Christian worship, undoubtedly many theories, stories, rumours and interpretations about their religious objects, practices and rituals, circulated freely among the Africans.

6.2 Medicine and diplomacy in uTonga and uNgoni

During the 1880s, the most important groups for the missionaries were the Ngoni in the highlands to the west of the Lake Malawi and the Tonga at the lakeshore. The success of the mission depended on the successful diplomacy between rival African groups, not only between the Ngoni and the Tonga, but also between the rival Tonga leaders. Different groups vied for access to the missionaries and the perceived benefits that would derive from an alliance with the Europeans. In these circumstances, medicine became, for the missionaries, a special and potent tool which could exert informal influence. The missionaries

42 Laws’ diary, entry for 2 May 1882. EUL Gen. 561/3.
43 Cairns 1965, p. 200; Livingstone 1921, p. 196.
44 Linden 1974, pp. 25-32; Liweve 1982; McIntosh 1993, p. 83; Marwick 1970, p. 90. Cf. Hunt 1999, p. 55.

were particularly keen to use medicine in their formative contacts with the Ngoni, whom they had come to regard as the dominant people in the region. In 1877, Cape Maclear was visited by a (Southern) Ngoni "minor chief or headman" and his followers. Laws showed them around the station, and believed that the Ngoni were "deeply impressed" with the rows of medicine bottles at the dispensary. Aside from his medicines, Laws was keen to demonstrate the use of the rifle and the revolver to his visitors.[45]

According to W.P. Livingstone, before the missionaries were allowed to meet the Southern Ngoni paramount, Chikuse, in 1878, the spokesman for the paramount asked, "Will any evil, any sickness or death come to our village on account of your visit, and will you, when you go, take all your spirits, with you, not leaving even one to plague us afterwards". Laws, whose words were translated by Koyi, replied that sickness and death had been in the village before the missionaries arrived and that Laws only had medicines for "the treatment and cure of bodily ills". In his account of the meeting published in 1879, Laws stressed that he *"repudiated all connection with medicines, other than those we employed in the treatment of sickness"*, and it was only after this promise that Chikuse himself appeared. William Koyi's linguistic skills enabled relatively fluent communication on this occasion. Significantly, the missionaries were treated with suspicion not only because of their unknown medicines, but also because of the potentially harmful spirits they brought with them.[46]

When a party was sent to negotiate with the paramount M'mbelwa of the Northern Ngoni in January 1879, the missionaries presented Laws, the head of the party, as a healer of the sick. In retrospect, both Laws and Fred Moir of the ALC believed that this was a significant advantage to them. During the initial visits, Laws treated Ngoni women including the paramount's head wife and one of the wives of M'mbelwa's brother.[47] This showed a certain degree of trust from the Ngoni elite, and placed the influential women of the ruling clan at the centre of a discussion about the relationship between the missionaries and the Ngoni. Three months later, Laws demonstrated the power of his chloroform and knife to two Ngoni messengers. He operated upon a man with a tumour on

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45 McCracken 2000, p. 112; Livingstone 1921, p. 122; Thompson 1995, pp. 30-33. The fact that missionary medicines were usually kept in glass bottles was also significant: glass was rare commodity in Central Africa, and it could have magical associations. In some interpretations, glass was associated with water, in others with fire. The glass windows of mission stations were initially regarded with some suspicion, and the story of Ngoni warriors being frightened off the Njuyu station in early 1886 because they saw the red reflection of sunlight in the station windows and thought this could be fire caused by European medicines, could be understood in this context. In 1926, this story was told to Jack Martin by old Mawelera Tembo. Martin 14 November 1926. Sinclair 2002, p. 259.

46 Laws 1879; Livingstone 1921, p. 150. The details of the dialogue in Laws' biography cannot be confirmed from primary sources, but the events in the book match the description written by Laws in 1879. For the Ngoni, the spirits of their dead adversaries were regarded as being a major threat to health. Soko 1987; Vail 1979, p. 213; Waite 1992, p. 215.

47 Laws 1886, pp. 20-21; Moir 1924, p. 25. Alongside the display of Laws' medical skills, however, was the display of European firepower to the Ngoni warriors, demonstrated by the marksmanship of Moir.

his shoulder, and claimed that *"their astonishment at the effects of chloroform were unbounded."* This was a crucial operation, and Laws took the patient from Livingstonia to Blantyre, where he was assisted by Dr Macklin and two laymen. Laws did not want to risk "any mishap"[48] as he was sending what he felt was a crucial message of missionary might to the dominant military power of the region.

The first major surgical operations among the lakeshore Tonga were not performed until 1882. Laws once again demonstrated the power of chloroform, inviting local chiefs to witness the two operations, an excision of a tumour on the side of the nose and an amputation of a hand with a "fatty tumour". The operations were performed in late December with Dr Peden from Blantyre assisting Laws. Both patients were women: Yasoro from Koko and an unidentified woman from Kapeta's. Laws noted with satisfaction that the effects of chloroform "amazed" the chiefs. Laws continued to be careful when selecting those operations he undertook at Bandawe, believing that his fame as a surgeon was crucially important to the success of the entire mission. He refused to undertake many operations where there was an appreciable risk of an unsuccessful outcome.[49]

Bandawe dispensary practice

During 1882, Laws reported that 3,104 African patients were treated, 800 of whom were seen on journeys. The fact that over one quarter of all cases were seen on missionary tours indicates the effort that Laws put into establishing his reputation as a healer in the region. February was the busiest month of the year, with 524 attendances at the dispensary: 110 from Marenga's, 95 from Chikoko's, 61 from Chimbano's and smaller numbers from four other villages (of the headmen Kanguli, Kwarara, Katonga and Fuka); twenty-three cases were from the mission station. During the busy period of January and February 1882, it was predominantly women and children who attended the dispensary, with their most common complaints being stomach-aches and ulcers. According to Norman Long, the Bandawe station was equidistant from Marenga's and Chimbano's and early missionaries established a network of socio-economic ties with villages within a five miles' radius of the station.[50] Marenga's, Chimbano's and Chikoko's villages were all closely connected with the mission from an

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48 Laws to Main 26 March 1879. NLS, MS. 7876, 247; *FCSMR* June 1879, pp. 137-138.

49 Daily Journal of the Livingstonia Mission, entries for December 1882. MNA 47/LIM/10/2; *Report on Foreign Missions for 1882*, pp. 64-65; *FCSMR* August 1882, p. 235; Bandawe Station Journal entries for 22 and 28 July 1883. NLS, MS. 7911; Livingstone 1921, p. 97.

50 Daily Journal of Livingstonia Mission, Entries for January-February 1882. MNA 47/LIM/10/2; *Report on Foreign Missions for 1882*, pp. 64-65; Long 1962. According to Long, Katonga, Fuka and Zoani, who did not have such close ties to the mission, had closer contacts with the Swahili. It is, thus, possible, that they also had some access to Islamic medicine.

early stage, and medical aid, together with trade and employment, was one of the strengthening ties.

It appears that Laws and Scott were successful in their promotion of themselves as healers to the extent that an increasing number of people were willing to try their medicines. Laws had established good relations in particular with the chiefs Marenga, Fuka and Chimbano.[51] He rarely undertook serious cases with the exception of emergency cases, particularly those wounds inflicted by wild beasts or violence. In February 1883, two seriously wounded men were brought in after a fight, both with gunshot wounds. Laws offered to amputate at the hip joint of the first patient as this was the only chance to save the man's life, but *"the man's friends would not hear of it"*, and Laws did not want to insist on the operation as he held the case to be almost hopeless. The bleeding was staunched as far as possible, and an opiate was administered. Laws also held amputation to be the best course of action for the second patient, but again the man refused to consent to the operation: *"How shall I walk? seemed to be of more importance than shall I live"*. The injured leg was placed on a long splint and the patient was housed in the old school building. Meanwhile, the first patient died. Two days later, the survivor was in the doctor's opinion, *"fairly well"* but *"considers himself dead"*. The old school was converted into a hospital, to house two more in-patients: a "boy" with a spear wound and another whose hands and legs had been savaged by a crocodile. On 7 April, the crocodile case was "discharged cured". Laws arranged for either Dan or Albert, his closest African associates, to read the Scriptures and engage in prayer with the two remaining in-patients every day.[52]

Immediately after the discharge of the first crocodile case, another man, who had been severely mauled by a crocodile, was brought to the station. He was nursed at the station for nine days, but Laws saw that *"gangrene had set in"*, and ultimately blamed the patient's death upon a local method of treatment which had been applied before his arrival at the mission station. The chief Katonga and the two wives of the dead man, who had been at the station with the patient, thanked Laws for his efforts. The doctor was pleased, noting that *"Such expressions of gratitude are rare"*.[53] Because the patient was nursed intensively for several days on the mission station, the therapy managers wanted to thank the healer even though he had failed. It is noteworthy that, again, the chief of a patient's village was directly involved in this particular interaction. Most of the early medical exchanges were short with little communication between the missionary practitioner and African patients: during a typical consultation, medicine would simply be dispensed or an ulcer would be cleaned and dressed before the patient left. Though the missionaries liked to stress that they were treating people without asking for payment, they did look for an expression of gratitude from their patients, and they could feel rejected, even abused, if gratitude was not shown.

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51 *Livingstonia Mission of the Free Church of Scotland at Lake Nyasa: Eleven Years' history and appeal*. Glasgow 1886, p. 13; McIntosh 1993, p. 87.

52 Bandawe Station Journal entries 18 February – 7 April 1883. NLS, MS. 7911.

53 Ibid., entries for 9-19 April 1883. NLS, MS. 7911.

Laws' failure to save the man wounded by a crocodile apparently dented the missionaries' reputation, possibly because he had scornfully removed all the local dressings and medicines which had been applied to the wounds. Six months later, William Scott reported that, when three men were bitten by a crocodile in the neighbouring village, *"We were not sent to because last time a man died after being bitten when he was taken here."*, although one of the men had lost an arm and another a leg.[54] If Scott was correct, local opinion was quick to condemn the shortcomings of missionary therapeutics, and Laws' policy of avoiding surgical failure almost at all costs was sound from this point of view.

Scott continued Laws' programme of medical evangelist tours in the villages surrounding Bandawe in 1884 and 1885. A typical visit consisted of an audience with the chief or headman, an evangelistic meeting and treating the sick: medicines were dispensed and the more serious cases were invited to the mission station. In this way, politics, evangelisation and medicine were combined. Missionaries and village leaders often exchanged gifts during these visits.[55] In April 1885, Scott, Smith and nineteen mission men and boys set off in a mission boat for a tour of the lakeshore villages. They spent a night at Kangoma's village:

> Kangoma was rather dry at first and did not seem inclined to welcome us. Afterwards he became very friendly and gave us a goat and also some bananas. The boys got plenty of nsima and a fowl &c. I treated a great many of sick people and drew a good many teeth (12)… A good many patients in the morning... Cough and Bellyache being the principal complaints. We had a meeting with the people. Well attended... Ntonda interpreted my Tshinyanja into Tshitonga after I had spoken.[56]

"Cough", "Bellyache" and toothache were complaints that a patient could demonstrate visually for the doctor, thus bypassing the need for a common language. Ntonda or other mission associates probably translated for the doctor in his temporary "clinic" when a patient's symptoms were more complicated.

In the next village, the missionaries were told that the headman, "Ishigo" (Chigawo) was not present, and the people were wary because of the recent visit by the British consul, but Scott *"gave a few medicine and this attracted them and made them a little more friendly."*[57] The dispensing of medicines was a successful way of dispelling suspicion, but the missionaries had to be careful which cures they offered. Furthermore, often they could not spare their most effective drugs, notably quinine, for African patients. In March 1884, Scott wrote to Laws in Scotland, arguing that as quinine was "cheap now", the missionaries could afford to give it to Africans suffering from fever, but only if

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54 Private Journal of William Scott, Bandawe, 1883-85. EUL, Gen.1942. Entry for 17 October 1883.

55 Bandawe Station Journal entries for 20 December 1884 and 17-18 April 1885. NLS, MS. 7911; Private Journal of William Scott, Bandawe, 1883-85. EUL, Gen.1942. Entry for 20 December 1884.

56 Ibid., entries for 18 and 19 April, 1885.

57 Ibid., entry for 19 April 1885.

more supplies were sent from Britain. In order to conserve stocks of quinine for the Europeans, Scott had stopped giving any to Africans at this time.[58]

After Scott's departure in January 1886, the recently-arrived Dr David Kerr-Cross took charge of Bandawe station. He soon found himself in the midst of fighting between Tonga chiefs. Cross and Smith were called upon to treat Chigawo,[59] who had been shot in the arm. The missionaries were reluctant to take on the responsibility of the case, but as they were surrounded by armed warriors, they felt unable to refuse. The doctors tried to make it clear that they would not accept ultimate responsibility for the chief's recovery if anything went wrong.[60]

In this case, the wounded chief and his councillors took the unanimous decision to consult the missionaries. Cross and Smith would have been unable to refuse to treat the chief. Although the missionaries would have been aware of the potential benefit if they were able to build up a relationship of trust between themselves, they would also have felt under significant pressure to proceed (and succeed) with the treatment. In a volatile situation, treating an influential leader could offer the opportunity to gain trust and the possibility of exerting some influence, but the doctor could also feel pressurised or threatened.

Chigawo's arm was dressed, a splint was applied and he was taken to the station for further treatment. At the same time, the chief Marenga who led the opposing group, called on the missionaries to visit his camp to attend the wounded, and they leapt at this opportunity to present their proposals for peace, and were delighted when a truce was called shortly afterwards. Chigawo stayed at Bandawe until April when his arm was healed and the splints were removed, and the missionaries had a number of "interesting conversations" with him during his stay. Though the bullet remained lodged in his arm, and still caused him pain, Cross regarded the treatment as a success. The neutrality of the missionaries in this conflict was crucial to the success of their proposals, as the fighting had in fact resulted from the friction between those Tonga leaders who had been seen to benefit from the alliance with the mission, and those who had not.[61] Giving medical aid to both groups was a demonstration of neutrality and a gesture that showed that both sides had equal access to European medicine, a potential source of power. The ongoing treatment of a chief gave the missionaries the valuable opportunity to engage a prominent leader in conversation.

Chiefs themselves were only rarely treated at a mission station. The only clear case in the Bandawe records kept by Laws in 1881-82 is of Chimbano, who was treated for a "hurt eye" on 17 and 19 January 1882. Five days later, eleven people from Chimbano's village, all women and children, were treated for

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58 Scott to Laws 7 March 1884. NLS, Acc. 9220, (1) (ii).

59 Chigawo, whose name the missionaries wrote as "Zhigo" was the son of Mankhambira, and later took on that name. Consul Goodrich considered him in 1885 to be the most important chief in Chintheche area. Long 1962.

60 Bandawe Station Journal entry for 25 February 1886. NLS, MS. 7911.

61 Ibid.; Bandawe Station Journal entries for 6 March and 10 April 1886. NLS, MS. 7911; McCracken 2000, pp. 112 – 113.

ophthalmia. It seems that Chimbano, satisfied with treatment of his own eye, sent his people, possibly his own wives and children, to be treated by Laws.[62] Normally the chiefs made their requests for medicines through a middleman or expected to be visited in their own homes. When chief Katonga died in early 1884, Scott was surprised as he claimed that not even the other Tonga leaders had been aware of Katonga's illness. However, a week earlier, Scott, himself, had prescribed medicines to Katonga for constipation. He had not seen the chief but had given medicines first to a messenger and the following day to Katonga's son. When no further requests were received Scott assumed that the patient had improved.[63]

Chigawo's lengthy stay at the station during March and April 1886 was an exceptional case of a powerful chief being under constant missionary medical and surgical treatment at the station. In addition to treatment, the growing friendship was reinforced by the sharing of food, with missionaries offering the chief provisions from their table. Chigawo was shown the "new" things at the mission house, and he, along with his men, frequently attended religious services at the station.[64] Such a long residence at the station allowed the chief to observe missionary life and may have helped to dispel some of the rumours and myths about the "whites" (even if he had believed these in the first place). He had also undoubtedly witnessed the missionaries' regular bouts of fever, which may have undermined the image created by the successes of missionary medicine to some degree.[65]

While missionaries emphasised the use of medicine in their relations with African chiefs and headmen, the Bandawe dispensary statistics from the 1880s suggest that the majority of patients were children, presumably many of them mission pupils. African men were treated more frequently than women, but chiefs themselves were rare visitors. Women and children were largely treated surgically, men medically.[66] Patients who were only given medicine were in a stronger position in the doctor–patient relationship than those who were treated surgically at the dispensary, especially if the medicines were delivered to them by a third party, as appears usually to have been the case with chiefs. The fact that women and children received surgical treatment more often than men, (above all for tropical ulcers, abscesses and ophthalmia) reflected the economic, social and nutritional realities of uTonga. These cases tended to peak

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62 Daily Journal of the Livingstonia Mission, entries for 17, 19, and 24 January 1882. MNA 47/LIM/10/2. Chimbano seems to have been a central figure in therapy management and refereeing process between Laws and many of his patients. See Laws' diary entry for 14 July 1883. EUL, Gen. 561/3.

63 Scott to Laws 7 March and 17 July 1884; Smith to Laws 25 January 1884. NLS, Acc. 9220, (1) (ii).

64 Cross to Laws 1 May 1886. NLS, Acc. 9220 (1) (iv). The missionaries' observation of rainfall seems to have interested many, and there was speculation that the missionaries had rain-making powers. Bandawe Station journal entry for 11 March 1886. NLS, MS. 7911.

65 For example, Dr Cross was ill on several days in March and April. He was occasionally delirious with a very high fever. Bandawe Station Journal Entries for March-April 1886. NLS, MS. 7911.

66 Appendix 2.

during the rainy season. As many of these ailments were the result of poverty and malnutrition, the seasonal hunger from November to February, which affected the poor, women and children most acutely,[67] was a significant cause of many illnesses. The fact that missionary dispensary offered free treatment at this time made it a viable therapeutic option for everyone within walking distance.

The poison ordeal

The *mwavi* poison ordeal was one Central African custom connected to medicine, religion, politics and justice that the medical missionaries attacked with particular force in uTonga during the 1880s. This ordeal, in which it was believed that the innocent would vomit the *mwavi* while those who were guilty would die, was frequently used by the Tonga to solve disputes and witchcraft accusations.[68] Laws had strongly condemned the use of the ordeal in the Cape Maclear area in 1876, and at the Cape the missionaries had halted the ordeal using force, as Black did in March 1877. Aside from other considerations, the ordeal could be seen as to be a direct threat to the missionaries' work.[69]

Following a complex case of accusations among the Tonga headmen after a *mwavi* ordeal near Chikoko's village in May 1883, Laws forcefully attacked the practice. He called together the Tonga chiefs to settle the issue through discussion (*mrandu*). Chimbano and Chikoko came, but Katonga and Mwanda, who had apparently administered *mwavi*, did not appear. Laws filled two glasses with water and "ferri. carb", which the chiefs *"at once considered to be mwave till told it was iron".* Laws then put strychnine on one glass and tartar-emetic on the other, showed the glasses to the chiefs, and stated that although the two substances looked to be identical, one was lethal while the other would simply cause vomiting. He argued that the poison ordeal could be manipulated

67 Appendix 4; Good 2004; Iliffe 1984; See also Kuhanen 2005, pp. 328-334. In December 1885, Scott observed that *"There is an epidemic of Catarrhal Ophthalmia, which generally comes at the beginning of the rainy season."* Bandawe Station Journal entry for 21 December 1885. NLS, MS. 7911. The Ngoni raids had prompted the Tonga to change their staple crops from maize to cassava, which rots quickly after it is lifted from the ground. Vail 1983, p. 241.

68 McCracken 2000, pp. 42-43; Vail 1979; Waite 1992, p. 218.

69 Black to Smith 3 March 1877. NLS, MS. 7876, 176; In 1876, Laws attempted to point out in broken chiNyanja "how foolish it was to attribute to dead matter the power of an omniscient God". However, at this point his language skills betrayed him, and he began to speak in rapid English. Laws, quoted in *FCSMR* February 1883, p. 47; Livingstone 1921, p. 94. In 1882, after their initial visit to Northern Ngoniland, the missionaries, and Mrs Laws in particular, had been blamed by some for causing the death of the paramount's son. Poison was administered to fowl, which vomited, clearing the "English" of blame. Mrs Laws apparently had patted the child on the head. The child later complained of headache. According to Laws, the boy was treated by a "native doctor" whose blood-letting treatment caused the patient to bleed to death. Witchcraft accusations were made, but M'mbelwa denied them. Livingstone 1921, pp. 200-201. According to Koyi, it was chief Mtwalo among the Ngoni elite who claimed that the missionaries were responsible. Koyi to Laws 26 August 1882, NLS, Acc. 9220 (2).

in this fashion.[70] In this way, he was trying to portray the *mwavi* specialists as partisan users of poison. To use Mudimbe's terms, Laws in this instance moved from derision to demonstration in his method. Arguably through his attempts to display the power of missionary medical science, Laws may have strengthened his reputation as a man with lethal medicines, already demonstrated through the poisoning of wild beasts,[71] rather than presented any clear and convincing distinction between Western medical science and local medical practices. The chiefs agreed in principle, and advised Laws which local drug was often used to help people vomit. The following day, Chikoko and Fuka came to the station, and informed Laws that a man involved in the recent ordeal dispute had fled the area, which effectively ended the *mrandu* for the time being. These two chiefs, whom Laws held to be most amenable to his views, said that they personally disliked the ordeal but that it was still popular among the people.[72]

The missionaries were in some cases called upon to interrupt the ordeal or to treat those who had been poisoned. In November 1886, Chikoko requested that Laws treat his sister who had not vomited the *mwavi*. Laws *"went down at once & gave a hypodermic injection of apomorphine, followed by other treatment. By twelve o'clock she was out of immediate danger but by no means particularly well pleased at the interference on her behalf…"* Through the use of emetics like apomorphine, missionaries were able to treat people who had not vomited the poison, but not everyone was grateful for such interference. The other woman had vomited during the ordeal, thus showing Chikoko's sister to be guilty. It is significant that the chief, who had already spoken out against the ordeal before the incident, called for missionary intervention regardless of the patient's own views. Clearly, his authority as a therapy manager overcame all resistance.[73]

By the end of 1887, Laws believed that missionary medicine was successfully challenging the ordeal, and that there was growing criticism against the ordeal itself in uTonga. He had successfully treated four *mwavi* cases during the year, but one patient had died. Laws held that successful treatment of poison ordeal cases had:

> ... afforded excellent opportunities for showing the folly of an appeal to such an ordeal, and have been the means of helping to break in upon the hold of superstition has got of the native mind. The women are the firmest believers in its efficacy, and, as patients, the most difficult to deal with. Perhaps this is due to the fact that the majority of them have to submit to this ordeal before marriage, and having escaped once, they believe they will do so again.[74]

In 1893, Dr Henry reported from the Livlezi Valley that five people had died and another forty had been poisoned in what was probably the largest poison

70 Bandawe Station Journal entries for 1-3 May 1883. NLS, MS. 7911; Livingstone 1921, pp. 202-203.
71 Mudimbe 1988, p. 53.
72 Bandawe Station Journal entries for 3 and 4 May 1883. NLS, MS. 7911.
73 Bandawe Station Journal entry for 20 November 1886. NLS, MS. 7911; Livingstone 1921, p. 225.
74 "Bandawe Report for 1887". *FCSMR* September 1888, pp. 267-268.

ordeal case treated by missionary doctors. Henry administered doses of zinc sulphate and water as an emetic, and reported that all those who survived the initial ordeal recovered.[75]

For those people who believed that the ordeal was a fair method of trial, such missionary interference must have appeared to be an obstruction of justice, and in the case of witchcraft eradication, a serious mismanagement of communal health. However, for those who for one reason or another were suspicious of the ordeal, or disapproved of the result, missionary medicine offered an alternative course when the poison was not vomited. Not all chiefs and headmen, both in uTonga and in uNgoni, had much faith in the ordeal. For some African leaders, missionary intervention was a new option that could be taken in political and judicial disputes even against the will of those people who had taken *mwavi.* In his anthropological study of the Chewa, van Breugel has argued that both the chief and the *sing'anga* administering the poison could determine the result of the ordeal beforehand, the chief advising the *sing'anga* of the desired outcome.[76]

Assuming that such arrangements existed among the Tonga leaders in the 1880s, the missionary doctor could be regarded as a complementary specialist, again to be consulted only in exceptional cases. Administering an emetic was a familiar form of treatment, as emetic medicines were used in local medical practice, however, the use by missionary doctors of apomorphine injections which took effect rapidly had no direct equivalent in African medicine. Historians of missionary medicine in Africa have noted the interest and enthusiasm often caused by injections in the early twentieth century. In Livingstonia, apomorphine injections were among the first injections given to Africans. For the missionaries, the poison ordeal was a prime example of "ignorance" and "superstition" having, "a hold on the native mind" that missionary medicine was capable of "breaking". Poisoning was a bodily phenomenon that could be directly affected by the use of European medicines, unlike beer-drinking, polygamy, sexual behaviour or a belief in spirits: as such, poisoning had great value for medical missionary propaganda.

6.3 Doctors and the Ngoni elite

In 1882, the missionaries were allowed to establish a pioneer station at Njuyu, near the residence of M'mbelwa. When the first medical missionary, Walter Elmslie, arrived in Njuyu in 1885, he introduced himself to the paramount as a teacher of the Word of God and a healer of all the sick. Healing was readily welcomed by the chief and the headmen, while teaching was prohibited. The

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75 *FCSMR* April 1893, p. 86.

76 In 1886, Elmslie wrote that M'mbelwa talked a man out of participating in an ordeal. He believed that the paramount did not believe in poison ordeal as *"he can judge men & things pretty accurately"*. Elmslie to Laws 17 October 1886. NLS, Acc. 9220 (1) (iv); van Breugel 2001, p. 221.

Ngoni were accustomed to consulting different medical specialists from among the subjugated peoples during their conquest, holding the Tumbuka doctors in particularly high esteem. Elmslie believed that the majority of local medical specialists were strongly opposed to the missionaries, feeling that their craft was in danger. Although Elmslie may have naturally exaggerated the level of animosity he faced (and the level of threat that missionary medicine posed to local specialists), such a reading suggests that M'mbelwa and the Jere royal clan regarded Elmslie as an alternative to the mainly Tumbuka doctors. They may have used him to limit the influence of local medical and religious specialists to some extent. The Ngoni "Councillors" whose power was increasing in society were largely drawn from those peoples who had been subjugated prior to the Ngoni conquest of the Tumbuka territory.[77] Elmslie followed Laws' methods during his early practice: he made an effort to treat the local elite, and was very careful not to undertake risky operations. Elmslie depended upon the mediating skills of William Koyi when making contact with, visiting, and treating the sick, particularly those patients from the ruling elite.[78]

Koyi, who spoke both Xhosa and Zulu, took up the observatory mission post in uNgoni in December 1878, and settled in Njuyu in early 1882, at a time of famine in the country. Soon after his arrival, Ng'onomo, M'mbelwa's supreme military commander, sent a request to Koyi for medicines to treat dysentery. Koyi had to turn down a number of requests for medicines, as his stores were limited and he frequently applied to Laws for additional supplies, especially quinine, castor oil and eye medicine. Castor oil was particularly popular, and people travelled a considerable distance to obtain it. On at least one occasion, Koyi successfully treated a man who had been bitten by a snake.[79] Although he often did not have medicines to dispense, Koyi visited and consoled Ngoni chiefs and headmen at times of sickness or death. They returned the courtesy: in March 1882, when Koyi was suffering from fever, the paramount himself visited him. On another occasion, M'mbelwa asked Koyi to obtain quinine and medicines to treat "rheumatism" from Laws, for himself and for his children.[80] The paramount was aware that Koyi only had limited medicines himself, but was also aware that Koyi had potential access to Laws' medical supplies, which interested him a great deal.

T. Jack Thompson has argued that for the Ngoni, Koyi was an ambassador for the mission rather than just the interpreter of Europeans. He was called *umteteleli*, which can be translated as an advocate or an intercessor who speaks

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77 *FCSMR* October 1885, pp. 299-300; Ross (ed.) 1996, p. 23; McCracken 2000; Mkandawire 1971. See Elmslie 1891, p. x.; Elmslie to Cross 8 January 1886. NLS, Acc. 9220, (i), (iv).

78 Private Journal of William Scott, Bandawe, 1883-85. EUL, Gen.1942. Entry for 11 May 1885.

79 Koyi to Laws 23 January 1882, 19 January 1883. NLS, Acc. 9220 (2); Thompson 1995, pp. 40-42. Castor oil was a trading commodity in the region before the missionaries arrived. The Tumbuka bought it from the Chewa of Mwase Kasungu before Ngoni conquest. Chavula 1976/1977.

80 Koyi to Laws 3 March 1882, 4 August 1883, n.d. NLS, Acc. 9220 (2). Rheumatism may have been referred to as "nyamakazi". See Lwanda 2002, p. 58.

on behalf of or in defence of someone, and who could have the authority to settle a case. He was given the Ngoni name *Mtusane,* "bridge-builder". His praise poem does not represent Koyi as a healer, but the fact that he frequently visited the sick, dispensed medicines, and that after the "Rain Question" of 1885-86 he was regarded, together with Elmslie, as having rain-making or rain-withholding abilities suggests that he may have been regarded as some kind of spiritual, if not explicitly medical, specialist. His role as *umteteleli* was essential to the success of the early mediation between Elmslie and Ngoni patients and their therapy managers. After Koyi's death, it seems that the Ngoni regarded the Lovedale evangelist George Williams as the *umteteleli* of the mission. Williams left Ngoniland in late 1888,[81] and during the 1890s Mawelera Tembo, one of the first two Ngoni converts, took on a role similar to that of Koyi, who had been his teacher.

Elmslie's early practice, although modest in extent, was valuable at a time when the advantages and disadvantages of the mission among the Ngoni were being fiercely debated. After Elmslie's arrival, the missionaries had greatly decreased the amount of cloth they provided to the Ngoni leaders as gifts. Initially, some Ngoni had believed that the whites would provide them with access to new powers and wealth, but these benefits did not materialise. Minor medicine continued to be the one useful service that the missionaries could provide.

Elmslie refused demands for calico and other presents, with one notable exception: after he had visited new villages, he invited friendly headmen who had given him fowls and other presents to the mission station, where they were given a "token in return". Frequently, these headmen were followed by patients who, in turn, would spread favourable reports of the doctor. Some of the Ngoni councillors even killed an ox when the missionaries visited them - a gift which the missionaries could not return in kind. However, only a few councillors had visited the mission by June 1885, to receive medical treatment, particularly tooth extraction, which was held to be "wonderful thing". In contrast to the considerable interest shown in dentistry, Elmslie was disappointed that the missionaries' religious message did not seem to attract the Ngoni elite at all. Nor were they over-awed by Elmslie's medical and surgical paraphernalia. When M'mbelwa visited the new European doctor he wanted to see Elmslie's surgical instruments and was *"determined to carry off a saw which he said was just the thing what he required for cutting the horns of his cattle. Any bottle he fancied he must have and it becomes a hard question as to how to deal with him"*. Elmslie wrote in a letter to Laws that although he had been pressed to give some of his own property to the paramount, he would not give up any mission property unless force was used.[82]

The bone saw, a symbol of European surgical power, did not frighten the paramount, who could see its practical usefulness as a tool for cutting horns

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81 Thompson 2000, pp. 99, 117-119; Thompson 1995, pp. 55-59. Following the drought of 1885-86, there were widespread beliefs in both uNgoni and uTonga that the missionaries had rain-making or rain-withholding powers.

82 Elmslie to Laws 9 June 1885. NLS, Acc. 9220 (1) (iii).

rather than the bones of men. Initially, M'mbelwa seems not to have been particularly impressed by Elmslie, whose calico gifts to the Councillors had been meagre. Sutherland observed that the Ngoni had little respect for the young, unmarried European missionaries, in contrast to the remote figure of Laws, who was regarded by M'mbelwa to be the father and chief of all missionaries.[83] In this respect, Elmslie's marriage in 1886 and the arrival of Mrs Elmslie marked a significant change in his status.

A particularly important figure for mission diplomacy was chief Mtwalo of Ekwendeni, brother of the paramount and his designated successor. Mtwalo and his family were interested in missionary medicine, but Elmslie treated them with some caution. The chief appreciated Elmslie's successful treatment of his son in 1887, but when the doctor believed Mtwalo was seriously ill in December 1887, Elmslie decided not to offer to treat him, as the doctor's presence was not requested by the chief. Earlier, Elmslie had treated Mtwalo's knee and received recognition from the chief for this and for the treatment of his son, who was *"brought forward by Mtwalo to show what my medicine had done."*[84] In retrospect, the missionaries believed that the treatment of Mtwalo's son, in particular, had enabled them to settle in Ekwendeni.[85]

Elmslie's medical practice may have been a success for mission diplomacy, but the doctor that felt it was professionally "unsatisfactory". In 1890, he was relieved by Dr George Steele, a young and inexperienced doctor. Elmslie explicitly warned Steele not to treat Mtwalo's leg when they met at Quelimane.[86] However, after Steele had made a promising start at Ekwendeni with the successful treatment of the chief's head wife, and Mtwalo asked Steele to treat him, the doctor decided to ignore Elmslie's advice. Mtwalo's wife had suffered from "extreme inversion of eyelashes", and Steele had successfully removed the troubling lashes using "Epilation" forceps from his pocket case. Steele believed that the treatment was successful and would save the patient from a lot of pain in the future. The chief's knee was a much more difficult case, however, and Steele was at pains to ensure that he did not promise too much:

> I said to him [Mtwalo] that I would apply remedies and do all I could for him, but was very careful to make him understand that I considered his leg very bad and would try remedies in the hope that he might be relieved somewhat, but I did not

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83 Sutherland to Laws 17 June 1885. NLS, Acc. 9220 (1) (iii). Sutherland described how Elmslie was welcomed with speeches which expressed the hope that the new doctors' arrival would bring success in war and raids and bring medical aid to the Ngoni. Then the people were amazed to see the doctors' paltry gifts, only eleven pieces of Turkey Red Calico, a variety so little in demand that the missionaries could not even hire people with it. *"Dr Elmslie thought everybody was pleased and looked majestic but we soon told him the reverse... Mombera told us... that if he knew his headmen were only to receive a strip of cloth to tie around their heads, he would never have called them together."*

84 Elmslie to Laws 10 December 1887. NLS, MS. 7890, 252.

85 Steele to Smith 15 August 1894. NLS, MS. 7877, 110. See also *The Livingstonia News,* October 1909, p. 70.

86 Elmslie to Laws 7 December 1889. NLS, MS. 7892, 286; Elmslie to Laws 12 April 1891. NLS, MS. 7895, 91.

> bind myself to cure him or make him able to walk on it again… In answer to this he said, 'Try, try'…[87]

The treatment of the chief's leg was to cause considerable anxiety for Steele. He put a "starch apparatus" on the leg, "with stimulating ointment below". As the patient complained of pain in the evening, however, Steele had to reluctantly remove the starch bandages and put on an ordinary bandage instead. Two days later, the doctor was called again, and he found that the condition of the leg had deteriorated. The ointment had been too strong, resulting in blistering of the skin. These complications made Steele *"… extremely miserable and bitterly repent that ever had I touched him."* He believed that the chief still trusted him, but wanted to rid himself of the responsibility of the case as quickly as possible, even fearing for his life:

> It is not the case itself I fear… the witchcraft and superstition I have to encounter, for were anything to go wrong with him, while he is in my hands not having any connection with his leg it would be blamed on me and what the result to our work here if not our lives might be would be hard to say.[88]

Under pressure, Steele fell back upon prayer to ease his mind. This case shows the difficulties experienced by the missionary who acted as a court physician. Steele felt that he was at the mercy of both his patient and public opinion. He had to change his treatment as Mtwalo demanded, and in spite of his initial careful statements, he believed that he would be blamed if the chief's condition worsened. Steele was greatly relieved, then, when he observed that the leg was returning to its previous condition, and he felt able to give up the case. By now, however, there were rumours at Ekwendeni that Mtwalo was dying. Steele at first believed this to be nonsense, as he had seen nothing alarming in the chief's condition. However, Steele's interpreter Chitezi (in all probability Chitezi Tembo) persuaded the doctor not to officially give up the case because of the persistent rumours about Mtwalo. Steele agreed, though he felt that because he had practically stopped all treatment, the case would eventually be closed. He was assured that Mtwalo was *"in fair health and not like a man who would die soon."*[89]

Within two weeks, however, he noticed, with some alarm, the Mtwalo was visibly weakening. The chief and his wives demanded that Steele "open" Mtwalo's knee, but the doctor refused. As the chief's condition worsened, Steele visited him daily and, although he suspected "chest trouble", he did not even dare to touch the chief with his stethoscope, fearing that he might then be implicated in any further complications. Mtwalo's wives disagreed with Steele's diagnosis, believing that the trouble was spreading from the knee to the heart and that consequently the chief's knee should be opened. Steele insisted that

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87 Steele to Laws 23 August 1890. NLS, MS. 7893, 182.

88 Steele to Laws 9 September 1890. NLS, MS. 7894, 16.

89 Steele to Laws 6 October 1890. NLS, MS. 7894, 51. If Chitezi [*Chiteyi* in the MS.] was Chitezi Tembo of Njuyu, he was, as the son of a famous healer and diviner, well informed of the medical practices and etiquette in Ngoni society. See Chapter 7.

"the disease was in the chest" but "few of them took this in". This interpretation suggests that the wives, important therapy managers, believed that there was a disease-causing agent in the knee that would be removed or released if it were "opened" by the surgeon's knife. Cutting the skin, often in order to rub medicines into the cut, or to "let the disease out" was a common procedure in Central African medical practice. Significantly, an "an old Atumbuka doctor" also refused to open up the knee.[90]

A few days after this argument, the chief died. Steele wrote to Laws that the cause of death was *"heart trouble complicated with angina like attacks and possibly congested lungs"*, and that the knee ailment was merely a contributing factor: Mtwalo had been unable to move from his hut with its "impure air". Furthermore, although he admitted that his diagnosis was inadequate as he had not fully examined the patient, Steele held that another important factor which contributed to the death could have been *"the wretched mental state the man was in from his superstitious notions of spirits hovering about him to do him harm, bad dreams etc."*[91] Thus, Steele gave a psychological interpretation of perceived African beliefs about sickness, suggesting that a belief in witchcraft actually undermines health: if a person believes he is bewitched and will die, he will lose faith in recovery and may in fact die from an illness that would not be fatal otherwise. Victorian missionary doctors placed significant emphasis on the mental, moral, and spiritual state of their European patients, and the idea that the patients' "spirits" were crucial to their recovery, was not alien to them. In addition, Steele blamed the "impure air" of Mtwalo's hut, worsened greatly by numerous "wives and wellwishers", as a significant contributory factor in Mtwalo's death.

To his relief, Steele was not blamed for Mtwalo's death. This was, in all probability, the verdict of the chief's wives who had considerable influence over the course of treatment. Although Steele had refused their request to open up the knee, they did not hold it against him to the extent that he would have been held responsible for the death: the Tumbuka doctor had also refused their request. Steele was a newcomer in the country, he had successfully treated Mtwalo's head wife and failed in his treatment of the chief's knee a few months earlier, but all other healers had also failed in their treatments. Steele had tried to avoid taking responsibility for the chief from the outset and had not even touched him with any of his European instruments. Following Chitezi's advice, however, he did not formally abandon the case, but continued to visit the chief, which was in itself an important gesture.[92] In light of all this, the verdict was that Steele had not killed Mtwalo either intentionally or accidentally. The fear of

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90 Steele to Laws 6 and 30 October 1890. NLS, MS. 7894, 61, 77; Scott 1985, p. 55.

91 Steele to Laws 30 October 1890. NLS, MS. 7894, 77.

92 In Ngoni society, the women of the royal clan wielded considerable political power, which was usually exercised as a group. Thompson 1995, p. 163. The head wives had to be familiar with medical practices, as it was usually the duty of a head wife to administer medicines to the chief. Oral testimony, L.H.T. 6 July 2004; M.M.D.S., 11 July 2004. In his study of the Chewa, van Breugel emphasises the importance of visiting a sick person in the village. A person who does not visit the sick can be suspected of witchcraft. Van Breugel 2001, p. 223.

witchcraft accusations was very real in the doctor's mind; nevertheless, his relationship with Mtwalo seems to have been friendly right up to the end. It seems that Mtwalo himself did not seem to have sought to blame any living person for his illness. On the contrary, he seems to have believed that spirits were involved: Steele's reference to dreams troubling the chief suggests that Mtwalo was frightened by spirits appearing in dreams, a central media of communication between the material and the spirit world. It appears that no one was in the end tried or convicted for his death.[93]

In September, after Steele had first treated Mtwalo and his head wife, he encountered another important patient. After he had dressed an ulcer of an old woman he thought was *"a mother of a young son of a headman"*, he was given a young bull as reward. The gift of a bull meant that after a successful therapeutic exchange, this wealthy family wanted to maintain a lasting relationship with the missionary doctor.[94] Between October and December 1890, Steele treated 186 people at the station, 136 men and 60 women. In addition, he recorded nineteen visits, of which six were male and thirteen female.[95] The records are incomplete, but in the recorded cases men visited the doctor about twice as often as women, while the women (like the chiefs) were more frequently visited in their homes. It seems that in Ngoni society men were usually in charge of face to face negotiations with the healer, although older women within the family (whose influence was largely invisible to the doctor) may have been important therapy managers.

Steele's eye practice, in particular, seems to have appealed to the Ngoni royal clan. In February 1891, Steele and Chitezi visited M'mbelwa, whose head wife and child, among others, had "sore eyes". Steele treated the eyes of the paramount's child. M'mbelwa was particularly interested in the new doctor's medicine chest and his pocket instruments, and examined them thoroughly. Steele presented him with a pair of scissors as a gift. Medical consultation was one of the ties that attached the missionaries to the royal clan, which formed increasingly close links with Livingstonia in the 1890s.[96]

Steele seems to have succeeded in securing some status as a medical specialist during his first year in Ngoniland. This was probably largely due to the advice and mediation of Chitezi and other African associates of the mission. Between 1893 and 1895, Steele undertook extensive evangelistic tours in Ngoniland. In 1894, Steele described one of these tours, which combined medicine and evangelisation with entertainment.[97] Steele's entourage consisted

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93 Steele to Laws 30 October 1890. NLS, MS. 7894, 77; Elmslie to Laws 12 April 1891. NLS, MS. 7895, 91. Levi Mumba called dreams as "the chief media" between the dead and the living in Ngoni society. "The Religion of my forefathers", MNA 47/LIM/4/16.

94 Steele to Laws 13 September 1890. NLS, MS. 7894, 20. For the Ngoni, the gift of a bull is a token of gratitude and a request for a continuing healer-family – relationship. Oral testimony, M.M.D.S, 11 July 2004.

95 Medical Report of the Nyuju Branch of Livingstonia Mission for Oct., Nov., Dec. 1890. NLS, MS. 7894. 149.

96 Steele to Laws 21 February 1891. NLS, MS. 7895, 47; McCracken 2000, p. 134.

97 Steele, quoted in *FCSMR* October 1894, p. 235; Thompson 1995, pp. 65-67.

of one African evangelist, three "boys" and eleven carriers. In the space of ten days they visited nineteen villages and held twenty meetings. Steele dispensed medicine to 320 patients and extracted 20 teeth. In one village:

> I asked for the owner of the village, but was told he was not at home. His brother being present, I asked him might I talk to the people. Having removed for him an aching tooth some minutes before, I thought one good turn deserved another…

Then, to Steele's surprise, the headman's mother was called upon to solve the matter: *"A quiet-looking woman now made her appearance, and having heard my request, said the object was good and had her consent. After the service I invited all sick people to my tent in the afternoon…"* On returning to this village later the same day, Steele found many patients waiting for him, and treated people until sundown.[98] As Thompson has pointed out, Steele's tours were significant for the mission and the subsequent expansion of Christianity within Ngoniland, through the interest it aroused in areas outside the few mission stations.[99] Medical practice, notably dentistry and minor eye surgery, played a substantial part in the expansion process.

6.4 Surgeons, patients and therapy-managers: cases of birth and amputation

In uTonga, uNgoni and the north end of Lake Malawi, the missionaries lived in the midst of societies who had their own long-established patterns of therapy management. In these circumstances the decision to approach missionaries was usually the decision of an individual or a group of key therapy managers rather than the patients themselves. The missionaries, who were not familiar with the kin systems of the people, often commented vaguely that the patients were accompanied by a group of "relatives and friends."

In both Northern and Southern Ngoniland, the women of the ruling elite played an important part in the acceptance of the missionary presence. The wives and mothers of chiefs and headmen were among the most important patients for the mission doctors.[100] Furthermore, they often played a significant role in the therapy management groups that took the decision to accept the missionaries' offer of therapy, or to approach the missionaries for medical aid. This was only partly recognised by the missionaries, who in their first contacts lacked insight into the hierarchies and relationships of local societies. When the importance of women, particularly older women, in therapeutic decisions, was later recognised, it was mostly in the form of derisive comments in missionary publications.

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98 Steele, quoted in *FCSMR* December 1894, p. 285

99 Thompson 1995, pp. 63-72.

100 In Southern Ngoniland, after his arrival in 1887, Henry treated the paramount Chikuse's mother, who had *"rheumatic pains in her limbs, and seems very well disposed towards us."* Henry 19 November 1887. Quoted in *FCSMR* May 1888, pp. 134-136.

Childbirth cases gave the missionary doctors an opportunity to interact, albeit infrequently, with female patients and African therapy management. This happened so rarely, however, that in the 1890s some commentators regarded childbirth to be a prime example of how African beliefs simply prevented patients from approaching missionary medicine which was so alien to them.[101] Nevertheless, in Livingstonia missionaries were occasionally called upon to assist in cases of difficult childbirth. Laws and Hannington were summoned to treat the Ngoni headman Chipatula's wife in April 1882. She had been in labour for five days, but as the doctors had no instruments with them, they were unwilling to intervene. The woman gave birth the next night, but the placenta was retained, and the doctors were called upon again. They *"separated the child & bound up the child & mother".* According to William Koyi, the doctors were "praised loudly" by the midwives who had attended the birth and had refused to touch the placenta.[102]

William Scott apparently treated the first major African obstetric case in Bandawe in April 1884. He noted details of the case in his journal: *"Delivered by the forceps a stiff case. Child dead. She is a young girl and has been ill for 3 ½ days. The natives are greatly astonished & seeing the success that has followed say they will come again with such cases."*[103] What motivated the therapy managers to turn to Scott, a twenty-four year old doctor who had been in Bandawe for only six months and whose language skills were, in all probability, very limited? The African intermediaries at the station presumably played an important role in this instance. Furthermore, this was not the first obstetrics case Scott had attended in Bandawe. A month earlier, his wife had given birth to a baby boy after a protracted labour during which forceps were used. The following day, Scott noted in his diary that many people came to see *"the Msungu baby"*. The news of what was apparently the first white birth in the lake area spread quickly. During the period of early contacts, the white baby was extremely interesting news. When the Scotts visited Nkhotakhota four months later, the Jumbe himself came aboard the mission steamer to see Mrs Scott and the baby.[104]

The interest aroused by the birth of a white baby was partly due to the influence the birth had upon local theories about Europeans. From the first contacts, some Africans had regarded the Europeans as radically different beings, to the extent that some claimed that they were spirits incarnate rather than men. Another theory held that they were fish-like creatures who emerged

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101 Johnston 1969, pp.; Cf. Good 2004, p. 354.

102 Laws' diary, entries for 25-26 April 1882. EUL Gen. 561/3; McIntosh 1993. In an article in 1951, Dr Agnes Fraser claimed that the Ngoniland mission was partly allowed because mission doctors had treated one of the paramount's wives in protracted labour, and the paramount was pressed by his wives to have the mission among them for the benefits it would bring to them and their children. She probably refers to the treatment of Chipatula's wife, for there is no reference of doctors treating the paramount's wife in childbirth, a case which the missionary doctors certainly would have reported. *Life and Work,* April 1951, p. 77.

103 Private Journal of William Scott, Bandawe, 1883-85. EUL, Gen.1942. Entry for 22 April 1884.

104 Ibid., entries for 18-19 March and 28 August 1884.

from the lake.[105] Whites were commonly associated with water and spirits.[106] The birth of the first white children disproved these arguments and gave credence to the notion that Europeans were people who reproduced in the same way as Africans. Eventually, Scott employed a woman named Kuluma as the baby's nurse.[107] Consequently, in the immediate neighbourhood at least, people were well informed about the Scott baby. The people who were at present at the station when Scott used forceps to deliver the baby, probably spread the news to the neighbouring villages, and some anonymous therapy managers decided to turn to Scott when faced with the crisis of a prolonged and painful childbirth.

Forty years later, Scott recalled this first African midwifery case:

> I well remember my first case in a young girl who had been some days ill, an ordinary primipara. The habit was for the expectant mother to go out of her hut to a newly erected shelter in the bush accompanied by some female friends. She sat in the arms of one of them, it did not seem to be an uncomfortable position. In my first case the patient was removed to a hut and put on a mat on the floor. Chloroform and forceps and soon all was over, but I had put her somehow in the centre of the hut where there had previously been a fire, and the result was that the whole of her left hip was a huge blister. However, all went well. They took her away, applied some dressing of leaves and it soon healed over. More cases followed, and I have seen a woman walk some miles to have the placenta removed and walk back again.[108]

"The female friends" were obviously local midwives. Scott's mistake of placing the patient among hot ashes was corrected by the use of a local treatment of dressing the blister with leaves. This was a significant example of medical pluralism in early medical encounters. In retrospect, Scott did not condemn all local childbirth practices. He believed that the *"removal to the bush no doubt tended to asepsis and kept them away from a dirty hut."*[109] Scott's removal of the patient from the shelter in the bush to the hut, and the burning of the woman probably gave the therapy managers some grounds for criticism, but Scott's use

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105 Among some lake shore people, it was first argued that white men, *azungu,* were incarnate spirits who had come out of a rock (Otter point) in the lake, held to be an abode of spirits, and a place where people sacrificed flour when passing it in a canoe. There appears to be a connection between flour, water, spirits and whites in this interpretation. An anonymous Ngoni teacher in Livingstonia in the 1920s told W.P. Livingstone that at the time of Laws' first visit to Ngoniland in 1879, it was believed that he was *"a fish because he lived on the Lake on a steamer"* Livingstone 1921, pp. 74, 161.

106 According to a Tonga school inspector in the 1920s, interviewed by W.P. Livingstone: *"When Dotolozi* [Laws] *came...We thought he was a fish and had no bones…He was a charmer; he charmed the whole district, so that the Ngoni could not come near. There was a story amongst us that at night he walked about the villages without being seen..."* Quoted in Livingstone 1921, p. 204. It can be suggested that in Schoffeleers' model of spirit classification, whites would be most likely to be thought of as strange spirits in human form, coming from outside the community and its known lineage connections, i.e. parahistorical spirits. Schoffeleers 1978, pp. 11-13. In this perspective, the evidence of Europeans having their own lineage, marriage and reproduction might have weakened the argument that they were not men but spirits.

107 Private Journal of William Scott, Bandawe, 1883-85. EUL, Gen.1942, entries for 29 March 1884 and 9 September 1884.

108 Scott 1985, p. 55.

109 Ibid.

of forceps was appreciated. Following this intervention, the therapy managers continued with the familiar local methods.

Between April 1884 and December 1885 Scott recorded that a total of nine obstetric cases were treated. One of the cases had been treated at the Bandawe station; the wife of Dan, a key mission associate, *"gave birth to a daughter. I was present, along with a number of other wives. All went well."* Scott's description shows his peculiar position as a male doctor-midwife: no other men were present at the birth. It is a common assumption that in most Central African societies, birth and midwifery were exclusively women's business. In his memoir, Scott wrote that *"There was a great repugnance to allowing a man to be present at a midwifery case, and it was very difficult to overcome it."*[110] There is no conclusive evidence from pre-colonial uTonga, but the evidence in Scott's diary is open to different interpretations. Firstly, it is not impossible that, unknown to Scott, there were male healers who were sometimes consulted in cases of difficult childbirth. T.C. Young suggests that some Central African medical specialists were known to provide medicines for infertility as well as contraception, but there is less evidence which suggests their direct involvement in childbirth. Secondly, it could be suggested that Scott was regarded as a white man, *muzungu*, who belonged to a different category of men and as such transcended the local gender divisions in exceptional circumstances, being a midwife among "other wives". Thirdly, his involvement may have been a last-resort emergency action resorted to regardless of prevalent medical theories. In any case, it seems that the birth of Scott's baby contributed to his being recognised as a specialist midwife of some kind. [111]

In one case recorded in Scott's diary the mother died before the doctor's arrival,[112] and although there were other complicated cases, it seems that in no case did the mother die after receiving missionary treatment. Furthermore, at least six of the cases came from two villages close to each other, Katendika's and Marenga's. There were four cases from Katendika's and two from Marenga's. This suggests that at Katendika's, key therapy managers had accepted Scott as a specialist to be consulted in cases of difficult childbirth. At Katendika's in October 1884 both the mother and child were reported to be well following the first African case of a live forceps delivery. Four months later, when Scott and Smith attended another childbirth case in the same village, forceps were not used, and everything again went well.[113] The last case Scott recorded was also in Katendika's. This time Scott was with Cross and forceps and chloroform were used, but with disappointing results at first: *"… She was*

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110 Ibid.; Private Journal of William Scott, Bandawe, 1883-85. EUL, Gen.1942. Entry for 6 August 1884.

111 Young 1931, pp. 32, 89-90, 119. If birth practices in the area were informed by categories of "hot" and "cool", and if people in childbirth were required to be "cool", it is possible that white men, who were sometimes considered to be spirits, were classified as "cool" and therefore able to attend the birth. Cf. van Breugel 2001, pp. 173-175.

112 Private Journal of William Scott, Bandawe, 1883-85. EUL, Gen.1942., Entry for 21 June 1884.

113 Ibid., entries for 30 October 1884, 22 February 1885.

in child bed we gave chloroform and then tried the forceps but ignomiously failed. We gave large doses of ergot and this produced a delivery ere morning."[114] It seems that the two doctors were humiliatingly at loss in their initial handling of the case.

By early 1885, European doctors had established something of a reputation as emergency midwifery specialists beyond Bandawe. In June 1885, Elmslie wrote from Ngoniland that he had had a "*goodly number of obstetric cases not ordinary ones which I never saw but such as require instrumental or other active treatment.*" Elmslie, a young and inexperienced doctor, felt that he was "*always quaking*" when treating such cases, as he had no ergot and twice he had "*difficulty in controlling the haemorrhage*". Lacking instruments, he was forced to treat a case of a hydrocephalus foetus with only a gouge, "*not a very easily manipulated instrument but the case went well and has me a greater standing*". The mother survived.[115]

If missionary intervention in cases of prolonged childbirth did not convince therapy managers, they would intervene or cancel the treatment. In 1888, Elmslie wrote of a "*curious case… a nastier case I never saw*" after childbirth. After Elmslie's initial surgical intervention, the therapy managers intervened. Elmslie was not allowed to touch the woman again but was allowed to give medicines. It seems that local healers in Ngoniland occasionally assisted in childbirth by sending medicines to midwives or therapy managers if required, but did not touch the pregnant woman.[116]

Although Laws was occasionally called upon to attend midwifery cases in Bandawe – in the late 1890s there were enough cases at the station to justify the construction of a separate maternity ward – Laws was convinced that midwifery was not a field of specialisation for the missionary doctor.[117] Apart from the fact that midwifery cases were relatively rare, it seems that the early doctors themselves were reluctant to treat obstetric cases, and generally disliked the practice. Victorian prudery, professional inexperience, and the fact that the doctors were forced to deal with female therapy management in African childbirth cases all contributed to this.[118] In contrast, complex surgical operations, notably the amputations of tumours and limbs, could be regarded as masculine and heroic practice in which the missionary surgeon was in a remarkable position of power.

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114 Ibid., entry for 20 December 1885.

115 Elmslie to Laws 9 June 1885. NLS, Acc. 9220 (1) (iii).

116 Elmslie to Laws, n.d. NLS, MS. 7891, 70. Elmslie retold how he was called upon only after "native doctors" had been consulted, to treat a pregnant wife of the paramount chief's half-brother. The incensed doctor refused the request. Elmslie to Laws 6 June 1887. NLS, MS. 7890, 127.

117 Laws to Wilson 13 January 1913. MNA 47/LIM/1/1/14, 54.

118 Childbirth had been the domain of female midwives in the West until the late nineteenth century. Leavitt 1987.

Cases of amputation

The introduction of limb amputation was a significant change in mission surgery. It was a drastic and visually powerful form of surgery, but it was also ambiguous in its demonstration of benevolent medical missionary might. Amputating a limb meant running the risk of further complications, not to mention the physical handicap the patients would suffer even if everything went well surgically. Limb amputation demonstrated the skill of the surgeon and the sharpness of his instruments, but in a terrifying way. It is not clear to what extent amputation was practiced in pre-colonial Central Africa; some sources suggest that it was known only as a method of torture and punishment.[119] William Scott claimed in 1884 that *"the use of cutting instruments for disease"* was a novelty to people in the Bandawe area, in comparison with the established practice of *"getting medicine to take"*. In his memoirs, however, he recalled that local healers *"sometimes cut the skin over the part affected to let the disease out."*[120]

Paul Landau has argued that in Southern Africa, therapeutic surgery was rare and cutting the body clearly distinguished missionary therapies from local methods. In Landau's words, to Southern Africans, "cutting the body was a discorporation, a metamorphosis of the Self." Popular images of body-cutting in Southern Africa were evil and perverse, often connected to witchcraft and sorcery. As Landau points out, negative images of body-cutting were also apparent in Victorian Britain, most notably in the case of Jack the Ripper.[121]

Among the most difficult operations which the early missionary surgeons performed were the removal of tumours; a type of surgery with very visible results. In 1887 Dr Cross removed a tumour weighing 41 lbs. from a patient with an "elephantiasis arabum". The patient left "quite recovered" and Cross believed the case created "no little sensation in the neighbourhood".[122] In 1894, Cross that he had recently performed five "major operations" and had removed tumours weighing between 10 and 50 lbs.[123] According to Cross out of twelve operations he performed during the course of the year, only one patient died following surgery. Nine of the operations were elephantiasis cases which Cross regarded as being the most interesting and challenging surgery, and he wrote with enthusiasm: *"Elephantiasis tumours in various parts of the body are wonderfully common… and I am being forced to make this quite a speciality."*[124]

The Livingstonia missionaries had "cut" tumours from the outset of their medical practice, but apparently limb amputations were not performed until the early 1880s. The most radical form of missionary surgery, it was an uncommon operation during the first decades of the mission and the patients

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119 Livingstone 1921, pp. 62-63, 319. Laws' English-Nyanja-dictionary in 1894 translated the verb "amputate", or "cut, to separate with an edged instrument" as *ku dula.* Laws 1894.

120 Scott, quoted in *FCSMR* April 1884, pp. 111-112; Scott 1985, p. 55.

121 Landau 1996, pp. 275- 277.

122 Cross to Laws 12 August and 30 September 1887. NLS, MS. 7890, 156, 211.

123 Cross to Smith 2 November 1894. NLS, MS. 7877, 172.

124 Cross to Smith 8 January 1895. NLS, MS. 7878, 24.

usually refused to consent to amputation.[125] At the turn of the century, as the missionaries' surgical resources improved somewhat and the first permanent hospitals were established amputations were performed more frequently. Stories of people returning happily home after the amputation of a limb began to emerge in mission reports.[126]

Amputation was often performed in cases of emergency, on people mauled by wild animals, hurt in accidents or wounded in fights. In the 1870s and 1880s local fights and hunting accidents were the main causes of such injuries, whilst during the 1890s, there was an increase in the number of animal attacks on people. The "Arab War" during the late 1880s and the colonial wars of 1890s introduced colonial military surgery to the region. All of these factors contributed to amputations becoming more common in the region.[127]

It was obvious that such an operation was feared and that both European and African patients would often refuse to consent to an amputation.[128] However, Cross wrote from Karonga in the 1890s that he was amazed by the case of a patient who walked a considerable distance and requested that the doctor amputate his diseased arm, as it had been troubling him for some time. This was clearly an exceptional case. Cross had practiced in the north end for several years, and taken part in the Arab War as a surgeon. He had removed several large tumours with apparent success which had, in all probability, established him in the region as a specialist. The idea of travelling to consult a distant healer, or that distant areas had potential medico-religious powers was not alien to pre-colonial African healing cultures.[129]

The missionary publications, obviously, did not usually document patients' or therapy management groups' frequent opposition to amputations. *"Some prefer death with a diseased limb to life without it"*, Dr Prentice admitted in his first medical report in 1895.[130] At least one patient who refused to give consent to an amputation survived, and left the hospital with crutches and a "mangled leg".[131] Furthermore, the patients who underwent the operations were not always as happy with the results as the missionary propaganda presented them to be.

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125 See above; Livingstone 1921, p. 211.

126 See, for example, *Annual Reports for 1912,* p. 10; *1913,* pp. 14-15.

127 Johnston 1897, p. 441. Harry Johnston believed that Central Africans had *"remarkable insensitivity to pain"* which made them *"admirable subjects for operations"* without anaesthetic. Paradoxically, medical officer and amateur ethnographer Hugh Stannus claimed in 1910 that Central Africans did not feel pain as acutely as Europeans, but nevertheless they did not bear it as well as Europeans, who, Stannus claimed, had a greater supply of "nervous energy". Stannus 1910, p. 285. Such racist claims were never made by the Livingstonia surgeons in the missionary archive.

128 During the Arab War, Fred Moir was badly wounded in the arm. Cross recommended an amputation, but Moir asked for two days delay. The arm got somewhat better, and Moir was able to return to Scotland where the arm was successfully operated upon, "to some degree of usefulness". Revealingly, Moir believed that his recovery was due to "the great value of health of total abstinence and clean living under the most trying conditions." Moir 1924, p. 145.

129 Jacobson-Widding and Westerlund (eds.) 1989, p. 11; Ranger 1975a, p. 9.

130 Medical Report for 1895. NLS, MS. 7878, 304.

131 *Annual Report for 1911,* p. 11.

In 1906, Nurse Ballantyne described, in some detail, an amputation of the leg performed at the Institution:

> We have had a man from Ekwendeni in hospital for a week or two with a fearful leg – bone disease. An operation was necessary, and after the man felt at home with us, and happy, Dr Laws told him what had to be done, and also made it clear to him that very likely we should have to amputate his leg. He consented, and was prepared for an operation. The night before, however, he refused to have his leg off – we might only cut, as we had done another man opposite him. Dr Laws again told him we could not do anything unless we had permission to cut off his leg if necessary. Next morning…he said he was willing, and we were glad. Got everything ready, and when he was on the table, ready to be chloroformed, he sat up and said "No." We all stood mute for some seconds...Dr Laws said, "Well, off; there is another man waiting"; and he replied he would just let us do what we liked, so on we went... Everything went well, and the man is doing well, and so much better than before his operation. His leg had to be cut off...He is not a Christian, but we shall have him for some time yet, and are expecting great things.

The patient, who had seen his fellow-sufferer survive having merely been cut initially resisted the amputation and feared it so much that he refused again on the operating table before finally agreeing. He required long-term hospitalisation which the missionary nurse believed would be good for conversion. The mother's initial reaction reveals the extent to which the amputation could shock the patient's family: *"His poor widow mother was here to-day, and the loud wailing was pitiful indeed. No one to hoe for her now her son had lost his leg. He gleefully assured her he would be more able than before."*[132]

Six months later, Elmslie wrote to Laws from Ekwendeni, noting that he had met one of Laws' recent amputation patients, a man whose leg had been amputated at the thigh. It is extremely likely that the patient was the man referred to in Ballantyne's letter, considering the time, diagnosis (bone disease), place (Ekwendeni) and the general rarity of leg amputations. Elmslie wrote that the former patient complained of pain and that there was "*discharge of matter from the cicatrice*". Elmslie initially told the man that if the pain or discharge increased, he should return to Laws. In a letter written twelve days later, Elmslie mentioned that the man would not stay with him; apparently, Elmslie had, after all, offered to treat the man at the station, but his offer had been refused.[133]

About five months later, Elmslie met the man once again. There was no more discharge, but the man complained of constant pain. Elmslie believed that the leg had actually healed well, noting there was no sign of bone disease, and considered the pain to be the result of a "nerve nipped". Ignoring the patient's complaints of pain, Elmslie believed that Laws had every reason to be gratified as a surgeon. But the patient was not only complaining of pain. He was looking for employment with the missionaries, who had cut off his leg. Apparently he felt that particular responsibility lay with the surgeon, Laws, but because of the long distance to the Institution he instead approached Elmslie, who dismissed

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132 Ballantyne to Daly 1 November 1906. NLS, Acc. 7548 D 71, Letters to Livingstonia Sub-Committee 1907, p. 16.

133 Elmslie to Laws 10 and 22 May, 4 October 1907. NLS, Acc. 7548 D 67.

his demands. For Elmslie, the case was just further evidence of what he perceived to be an African lack of individual responsibility and a tendency to exploit the goodwill of the missionaries. Amputating the man's leg and saving his life had not been enough, but the surgeon should now employ his former patient and provide a livelihood for him.[134]

In the socio-economic context of early twentieth-century Northern Ngoniland, it is not surprising that amputation of a patient's leg at the thigh could have such catastrophic effects for the individual and his family. At this time, the Ngoni were increasingly turning to wage labour, and men had to travel considerable distances in search of work in European service, in particular to earn money to pay the taxes increasingly demanded by the colonial administration. In the region, the Livingstonia mission was the only potential local European employer, but at this time it employed just a few converts and the man was not a Christian. His mother was a widow, and it appears that he as the only child was responsible for hoeing her gardens. The mother and her son felt that the missionaries had a responsibility to help them after having performed an operation that had largely ruined the amputee's employment prospects. In the early days of the mission, it might have been possible to employ the man, but after the mission had become an established institution, most of the stations had been built, mission work was increasingly in the hands of the Christian converts, and the mission was suffering from a chronic lack of funds. Elmslie at least had no intention of employing the complaining former patient of a colleague at the mission.[135]

Breaking the doctor–patient relationship: the case of Loujoma

In April 1903 Elmslie wrote to Laws at length about a complicated gynaecological case of a Ngoni woman named Loujoma. She belonged to a wealthy family who owned, according to Elmslie, "scores of cattle". In the negotiations over Loujoma's treatment her mother played a pivotal role. Elmslie did not describe the case or the treatment in much detail, mentioning only that Loujoma had a fistula, and admitting that the first surgical operations had not been successful. It seems that her condition threatened to break up her marriage and Loujoma's husband was going to take back the cattle that he paid for her. At some point, the patient had been taken to Bandawe, where Dr Boxer had been in charge of her treatment. Dissatisfied with the therapy, Loujoma left Bandawe secretly, directly going against Boxer's orders. Later, she and her

134 Elmslie to Laws 4 October 1907. NLS, Acc. 7548 D 67.

135 In 1895, Elmslie reported that a regular patient who suffered from heart disease had been given an "easy job", out of pity, in the mission brick field for four months. He was later asked to pay for his treatment but he refused on grounds of poverty, left and later returned asking for sheep to pay to a local healer he had consulted instead. *Half-Yearly Report of Livingstonia Mission, July-Dec. 1895*, p. 15. Paying for treatment with labour was in theory best option while the mission stations were under construction, but in practice most patients were incapable of engaging in productive work. See *Annual Report for 1902,* p. 40.

mother came to Elmslie again at Ekwendeni, and she had *"used a vast quantity of medicine for local application"*. The doctor reprimanded them strongly, demanding total obedience from Loujoma if she was to be treated by missionary surgeons again. He argued that she should be sent to the Institution hospital, where there were several surgeons available, with the travelling costs covered by her family. The family, it seems, did not have faith in missionary surgery which had previously failed and Elmslie's suggestion that they should sell their cattle in order to pay for the carriers was rejected.[136]

Elmslie felt disappointed that he had not been able to treat Loujoma, but believed that he had to be firm and insist that the family pay for further treatment.[137] His surviving correspondence contains no further references to the case. This suggests that Loujoma and her therapy management group led by her mother severed their relationship with the mission surgeons on this occasion, if not permanently. Missionaries had failed to cure Loujoma and to establish trust, as demonstrated by her escape from Bandawe, and had demanded total obedience and payment for further treatment. In this case it seems that the therapy managers simply decided that it was not worth continuing the relationship.

Gratitude, payment and fees

The two cases above cast new light on a crucial aspect of the medical missionary enterprise, the demonstration of benevolence and good will. Elmslie repeatedly expressed a fear that the patients were exploiting the goodwill of the mission. He believed that offering free treatment left the missionaries particularly exposed to further demands from patients. Showing weakness in such situations would reverse the aims of medical mission. Instead of binding patients and their families to the mission through gratitude, the therapeutic relationship could bind the physician to increasingly demanding patients and their therapy managers, who would accept the benefits of missionary therapy but ignore the religious programme.

Secular Victorian doctors were also sensitive to a lack of gratitude, especially from their lower-class patients in Britain,[138] but for the early missionaries, gratitude had particular significance. Initially, the missionaries believed that the offer of free treatment was one of the strongest advantages in the promotion of mission medicine. Indeed, it was a requisite of the true Christian spirit. When the missionaries who offered their superior treatment

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[136] Elmslie to Laws 4 April 1903. NLS, Acc. 7548 D 67. It should be noted that according to Read, in Ngoni society all wealth with the notable exception of cattle was in the hands of the women who were heads of households. Read 1970, p. 139. Assuming this was also the case in Loujoma's family, and that her mother was the primary therapy manager it would seem that it would have been impossible for the mother to pay in cattle without the approval of the male head of the family, which may have complicated the situation further.

[137] Elmslie to Laws 18 April 1903. NLS, Acc. 7548 D 67.

[138] Brown 2004, p. 339, quoting Smith 1979, pp. 264-265.

out of kindness were compared with local healers who charged high fees for their ineffective therapies, the medical mission would rapidly conquer the medical market. Consequently, the missionaries would deliver a fatal blow to local beliefs about medicine and religion and prepare the ground for conversion to Christianity.[139] Free treatment was to some extent a pre-requisite for generating gratitude: if the patients paid a considerable medical fee, they might be far less inclined to listen to the missionaries' religious message afterwards.

The Livingstonia missionaries generally did not charge for their services until about 1908. It seems that fowls in particular were given as payment. Among the people of the lakeshore, fowls and goats were the most common mediums of wealth, but the Ngoni and Ngonde were able to make payment in cattle which were far more valuable. In uNgoni, Elmslie had noted that local healers were paid high fees, usually in the form of cattle or meat. In comparison, fowls were poor rewards.[140] Steele was given a young bull after treating a member of a wealthy family, but this seems to have been an exceptional case.

Elmslie in particular felt that free treatment undermined respect for missionary medicine, and even worse, made the missionaries susceptible to exploitation. He introduced fees in the 1890s initially just for vaccination and tooth extraction. The Ngoni had volunteered to pay for smallpox vaccinations when smallpox threatened the area in the mid-1890s. In Elmslie's Ngoniland practice, he chose to adopt the charging policy of African healers in order to gain professional respect and prestige. In Bandawe, Robertson echoed Elmslie's views in 1909. The proponents of fees stressed, in addition, that free treatment would "pauperize" the Africans. The introduction of fees was regarded as problematic after many years of free treatment, however. Agnes Fraser wrote that unlike in the case of school fees, medical aid could not be easily withheld, and that once people had been treated, it was difficult to make them pay. Furthermore, it was difficult to charge those who were regarded wealthy: when Fraser asked a woman to pay for her son's treatment after the doctor had learned from Donald Fraser that the patient's father was a headman, the woman refused, claiming the family were "slave people" and at one point dismissed Fraser's claims as *"Mzungu lies"*. Robertson argued that in Bandawe, migrant workers who had been in the south could easily afford to pay fees, but that the "genuinely" poor, the aged and children should be given free treatment in times of need. Elmslie advocated charging fees as part of the missionary

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139 Burns Thomson considered the problem of charging fees in his 1854 essay on medical missions. He considered that the issue was up to the individual missionary to decide, although the poor should not be charged and the rich be assured that the money did not go the individual doctor's pocket, but to improve the medical agency. This he believed *"would leave the benevolence and self-denial, manifest in the medical agency, to exert its natural influence undiminished, at the very time it was enriched."* Thomson 1854, pp. 42-43.

140 *FCSMR*, May 1886, p. 138; Medical Report for 1876-1877, Cape Maclear Journal 1875-1876, NLS, MS. 7908. In 1902, Agnes Fraser reported that during the year, she had received only one goat, the only payment exceeding a fowl in value. *Annual Report for 1902*, p. 39.

programme of moral regeneration. After the missionaries had established themselves in the country, the fees were necessary and would free the doctor from "medicine eaters" those with "trivial aches" and those who regarded medicine as a "charm". Elmslie even claimed that an African man could lie "idle" in the hospital for a year, and return "no worse than his neighbours", because his wives would have taken care of his gardens. This would be intolerable for a Presbyterian who saw all work as a necessary incentive for progress and elevation.[141]

The medical missionaries had moved a long way from the pioneer policy of offering free treatment in order to generate gratitude. This has to be seen in the context of the introduction of the colonial economy in the region, a process in which Livingstonia played a significant part. The mission's vision was to create a self-reliant Christian community which would earn enough to pay for its medical care. Early twentieth-century missionary medicine was more expensive and increasingly hospital-based, and the medical department like the entire mission had constant financial difficulties. In the policy of introducing fees, economic interests were combined with moral arguments. In African communities, under increasing economic pressure from colonial taxation, problems caused by migrant labour and mission school fees, the introduction of medical fees without any consultation caused resentment. As Agnes Fraser noted:

> Even with adults one feels horribly mean demanding some return for little medical help. If they realized it were a principle we were fighting for it would be a different matter, but I am afraid that as they see their flour being carried off into our boys' house, and their fowls being added to our stock, they think it is greed on my part demanding something in return for my services, in spite of my always trying to explain that we buy the things and wish the money to buy more medicine with.[142]

After the introduction of fees, medical attendances generally dropped in Livingstonia.[143] The introduction of fees might have caused less resentment, if the overall efficacy of missionary medicine had improved considerably in the first years of the twentieth century, but this was not the case. Thus, the policy of medical fees made it more difficult for Africans to consult the mission doctors and probably boosted African healers' practice rather than bolstered the reputation and prestige of mission medicine.

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141 Report for Ngoniland District of the Livingstonia Mission 1895. NLS, MS. 7879,31; *The Aurora* August 1900, pp. 35-36; *Annual Report for 1902,* p. 40. *The Livingstonia News* April 1909, pp. 27-30, June 1909, pp. 41-43.

142 *Annual Report for 1902,* p. 40.

143 *Annual Report for 1908*, pp. 28-29; Fields 1985, p. 109; McCracken 2000, pp. 271-274. In Ngoniland, Agnes Fraser observed that tooth extraction was one operation that was readily paid.

7 HOLISTIC HEALTH AND "REGENERATION" OF AFRICAN PEOPLE AND SOCIETIES, 1875–1930

7.1 Health and morality in Robert Laws' thought

A collection of Laws' sermons from 1883 provides an insight into his thought after his first term of service. In his sermons, Laws frequently discussed issues of spirituality and physicality, faith, sin, morality and character and the difficulties of living a Christian life in the African mission field. For Laws, the spiritual and the physical were two complementary parts of human nature, and similarly human knowledge could be divided into religious wisdom and scientific knowledge. God had provided man with both the book of revelation, which dealt with *"the unseen but Eternal, the spiritual forces of life and of the world to come"*, and the book of nature, revealed through various developing sciences. The book of revelation and book of nature were complimentary and could not contradict each other. Any apparent conflicts between science and religion arose solely from human error and a tendency to extremism in all sciences and scholarship (including theology) before the balance was restored through further careful study. Although he admitted that theology could be erroneous, Laws unequivocally held the revelation of God's will in the Bible to be superior to all secular knowledge.[1]

When considering human nature, Laws believed that the two books of revelation and nature together held the solutions to the problems of evil, sin and suffering. Sin was, for Laws, the "root cause" of all misfortune, sadness, war, slavery and disease. He argued that those who had searched for the causes of human failure in the purely "material elements of man" had resorted to asceticism and mortification of the body, but with little success. Instead, he believed that *"…the knowledge of sin, and the knowledge of God's cure for sin, can*

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1 Sermon VIII, 18 February 1883. MNA 47/LIM/4/11. These sermons, written in English, were addressed to the small missionary group at Bandawe. Public speaking was not among Laws' strengths. McCracken 2000, p. 69.

only come from God himself." The Bible provided the necessary knowledge about the sources of evil and how evil could be eradicated, as well as containing *"scientific thought...given in popular language"*. Some difficulty, however, lay in the interpretation and understanding in the:

> border land where things are not so clearly understood from the side of the science, where revelation does not use the exact terms which were supplied to it for the expression of the religious thought and knowledge there. [2]

Morality and health, both individual and collective, were located in this "border land" of religion and science. When examining the thinking of Laws, it is essential to bear in mind that, to him, there could be no real conflict between true science and true religion. The problems arose only in human interpretations of the truth. Likewise, in Laws' roles as a missionary minister and a scientifically-educated doctor there could be no contradiction, it was only a question of dividing resources between his spiritual and physical duties. Both the spiritual and the physical sides of human nature required daily attention, and neglecting spiritual needs was comparable to diseases which caused loss of appetite, starvation and death. For Laws, both body and soul could be starved to death.[3]

As Charles Rosenberg has noted, early nineteenth-century Western theories of health and disease were holistic. Health was negotiated by the individual's body and mind in interaction. Education, morality and emotions influenced decision-making, but volition and responsibility were at the heart of the speculative model of disease causation. Controllable behaviour was vital to health. Thus, medical theory underpinned the Christian connection between sin and sickness, and its emphasis on volition and control for at least two thirds of the century, whereafter the delicate balance between speculative mechanism and moral responsibility was disturbed in medical debates. The late Victorian period witnessed both the increasingly materialistic and reductionist framing of psychosomatic diseases, and the emergence of Christian faith healing. While scientifically-minded doctors (especially the new specialists of neurology) looked for underlying biological mechanisms to explain all disorders, proponents of faith healing followed the holistic theory of health with its emphasis on volition and control to the conclusion that the power of the soul ruled over the mind and the mind ruled over the body.[4] The thought of Laws, who undertook his medical and theological studies at a time when these debates over mind and body were becoming increasingly intense, must be understood in this context.

In Laws' view, God endowed men with brains, intellect, the faculty of reason and "the power of mind and will", and He then enlightened individuals according to their mental capacities. Men were teachable, and God would show

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2 Sermon XII, 25 March 1883. MNA 47/LIM/4/11.

3 Sermon XXIV, 1 July 1883. MNA 47/LIM/4/11. Cf. the discussion on Drummond and Stewart in Chapter 3.

4 Rosenberg 1989, pp. 195-196.

them *"His ways…complex...and yet governed by simple laws, arranged upon simple principles…"*[5] Many of these were revealed in the Bible, while others were to be discovered through science. God taught people through the Word, through the book of nature and through Providence.

For Laws, true religion and true medical science would always be in harmony. Therefore, what was good and healthy according to the Word, was also good and healthy from the medico-scientific point of view. Conversely, what was evil and sinful according to natural laws, could lead to punishment, in the form of illness. The long-established connection between sin and sickness was reinforced by this analysis. Considering the stern Old Testament God, in comparison to the loving God of the New Testament, Laws preached that:

> God is a God of justice and of inflexible rectitude in all his dealing with man. We see this in God's laws of nature, we see it and recognise it and the better we understand these laws by which He governs nature, or speaks through nature the purer we become and the better fitted for life and enjoy longer life.[6]

Knowledge of the loving God needed to be combined with knowing "the justice of God in nature" as well as "the heinousness of sin in its most appealing forms". Christians who understood both the Word and the laws of nature would live purer and longer lives. Laws did not question the existence of evolution in the natural world and drew comparisons between human behaviour and the survival of the fittest among animals. However, he was not a hardline social Darwinist who believed that this was, or should be, the case in every human society. The survival of the fittest was a struggle, which belonged to the "lower world", while in the higher, civilized world other forces were at work, the most important of these being the true religion, Christianity.[7]

For Laws, a man's religion should be "a living principle of his life regulating the whole of his conduct". Prayer and communion with God were central to Christian life, and the prayer meeting was the "thermometer of the Christian life" of a congregation. Christian life was defined by loving and sympathetic thoughts and deeds, alongside ceaseless internal scrutiny and a

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5 Sermon XIII, 1 April 1883. MNA 47/LIM/4/11.

6 Sermon XIV, 8 April 1883. MNA 47/LIM/4/11. Cairns (1965, p. 243) has quoted this sermon as evidence of how late Victorian missionaries in Central Africa viewed the Old Testament in light of violence and cruelty in Africa. This view, Cairns argues, "made it possible to explain, to justify and to interpret some past or anticipated crushing disaster [notably the imperial conquest] to an African tribe as divine chastening or retribution". Although Cairns's argument may have some general validity, in its context this sermon has no clear connection to imperial aspirations or any divine retribution upon Africans. Rather, it should be interpreted as encouragement and explanation aimed at missionaries suffering from illness and death, and fearing warfare in the region.

7 Ibid.; Sermon XII, 1 April 1883. MNA 47/LIM/4/11. Laws highlighted the slave trade in the Lake Nyasa region as an outstanding example of sin and its consequences and cited the fighting in Tongaland in the early 1880s as one example of predatory behaviour in human society. He seems to have disagreed with ideas of rigid theological and biological predestination. The first theological students at the Overtoun Institution were asked in Systematic Theology to discuss the statement: "God does not by predestination destroy that freedom in me which is essential to moral growth." McIntosh 1993, p. 152.

struggle for spiritual purity.[8] Laws' sermons are saturated with metaphors of health and cleanliness, and they shed light on his doctrine of missionary work and medical practice. In these sermons, the doctor and the minister were speaking in unison.

Laws used medical metaphors extensively in his preaching. In one sermon, he compared physical blindness to spiritual blindness, an inability to see God,[9] and accordingly, recovery of eyesight was equated to religious awakening. Furthermore, he pointed out that in the Bible, metaphors of illness were used to illustrate sin:

> …the spiritual condition of the unregenerate heart, described according to the physical condition of a body when it is sick…The very worst types of disease are chosen as those which best represent the sinful condition of the unregenerate man… That the leprosy of Naaman the Syrian should cleave to him and to his children. A terrible doom it was. A frightful disease leprosy was, and is.[10]

Leprosy was the "ideal" disease in Christian discourses of sin, sickness and charity, including medical missionary discourse and Laws stressed the combination of pity and loathing that the sight of lepers provoked, and the horror of the termination of the disease. This lethal disease was metaphor of sin in the Word:

> Sin is the leprosy, a far more virulent and deadly form, than any leprosy on this Earth. No escape from its grasp, no one is without its taint, no one can cure it...it lays hold on each one, and it dooms each one to death. And this is what we were...Darkness. Leprosy the type of our past condition, Darkness was the type of the world, the condition of the world as it is first brought before our notice, Darkness is the moral condition of man as he first appears to be...No man is pure. Moral darkness is over the whole Earth, and this darkness we have shared in...[11]

At this point in the sermon, Laws turns from the dichotomy of illness and health to the dichotomy of darkness and light. Both are, as Mudimbe has pointed out, salient features in missionary language used to describe Africa. The Christians should *"Walk as children of the Light"* (Ephesians V, 8), and Laws illustrates this by recounting missionary experiences at a sick bed in the (African) night:

> ...it may have been our duty to watch by some sick bed during the night...These are the hours of darkness the hours of which changes so often occur to the sufferer, requiring a watch to be carefully kept, when the struggle between the forces of life, and death, of returning health, or increasing sickness seems…to be at the deadliest battle, when the little touch here or there may help in a wonderful way, to…bring back again the loved one to health and strength again. These are the hours...which make us look and long for the daylight…when the first streaks of the daylight comes...Hope rises fresher and stronger in our hearts...the weariness of night seems to vanish…and we rejoice...because of the change that we have experienced. We have come from darkness unto light. Is not this just in the same way a picture of our

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8 Sermon XIII, 1 April; Sermon XVI, 22 April 1883. MNA 47/LIM/4/11.

9 Sermon XI, 18 March 1883. MNA 47/LIM/4/11.

10 Sermon XVIII, 13 May 1883. MNA 47/LIM/4/11; For leprosy in medical missionary discourse, see Vaughan 1991, pp. 77-81; 1994b, 183-184.

11 Sermon XVIII, 13 May 1883. MNA 47/LIM/4/11.

> spiritual condition. We were living in darkness enthralled by sin...Then arises the sun of righteousness with healing in his wings and coming unto His presence receiving forgiveness at His merciful hands...[12]

Accordingly, the missionaries must be bearers of light and healing in the world. This sermon illustrates the way in which the languages of medicine, disease and health, and missionary Christianity were interconnected. The teachings of the Bible, such as the nature of sin, could be understood through metaphors of medicine, and conversely missionary experiences of illness in Africa could be reinterpreted in religious terms.

In Laws' sermons, Africa was an unregenerate place, full of darkness, sin and disease in both a spiritual and a physical sense. Although the entire world shared these negative qualities, Laws believed the missionaries in Africa were brought *"more face to face with the evil in its flagrant forms."* War and the slave trade were the major African "evils" which Laws referred to in his sermon of June 1883. This reflected the social and political context of the mission in the Lake Nyasa region at the time. By contrast, illness was not particularly an African experience, but primarily a pioneer European experience of Africa. Laws' description of the vigil at the sick bed above all reflected the missionary doctors' experience of treating fellow Europeans who were gravely ill.[13]

Laws stressed that physical illness could affect the judgement of missionaries. Moral judgement was located in the mind, which was inseparably connected to the condition of the body. How then, were the ailing missionaries to judge others? For Laws, the only solution was to become like Christ. A careful study of Jesus' life had shown Laws that Christ was *"a perfect man…no side of His Character was developed to the exclusion of other side."* It was only by receiving the Holy Spirit and heavenly wisdom, that becoming Christ-like was possible. Jesus was pure, but still he lived in the corrupt world, mixing with corrupt people without becoming tainted.[14]

Being Christ-like meant being a perfect, healthy man. It also meant being able to judge others without succumbing to the adverse influences of mental and bodily ill-health. This was the ideal to which Laws aspired, and which he believed should be the ideal for all missionaries in Africa. Laws' thought can be compared with the ideas of perfectionism in nineteenth-century Protestantism on both sides of the Atlantic. The perfection of body, mind and spirit was connected to the "gospel of health", which aimed to create perfect women and men.[15]

Liberal Theology in Scotland in the 1880s and 1890s placed significant emphasis on the historical figure of Jesus and the Kingdom of God as preached

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12 Sermon XVIII, 13 May 1883. MNA 47/LIM/4/11; Mudimbe 1988, pp. 53-54.

13 Sermon XXII, 10 June 1883. MNA 47/LIM/4/11; "The fever", as noted in Chapter 5, was for Laws, "a piece of Devil's artillery" rather than a manifestation of sin. For the representation of slavery as disease in earlier missionary discourses, see Comaroff and Comaroff 1992, pp. 221-222.

14 Sermon IX, 4 March 1883; Sermon XXII, 10 June 1883. MNA 47/LIM/4/11.

15 For ideas of perfectionism in Protestant thought in America and Canada, see Opp 2000, pp. 41-43. Perfectionism and the search for holiness were closely connected to the temperance and hygienic movements of the late nineteenth century.

by Him. This contributed to the use of Biblical insights in social reform, especially within Laws' denomination, the United Presbyterian Church. For Laws, the realisation of the Kingdom of God in the world meant the creation of a spiritually and physically healthy society, and, in Africa, an ordained medical missionary was the ideal agent for this manly task. For Laws, Jesus the healer was one of the perfectly developed sides of Jesus' masculine character. Such an understanding was compatible with the Victorian notion of medicine as a masculine preserve and, for its part, begins to explain why Laws felt particularly uneasy with Waterston, a female missionary doctor. For Laws' generation, "doctor", as well as "missionary", was a male noun, and Waterston was doubly disturbing in this respect.[16]

Laws explained the fall of man into sin thus: *"He was led aside by Sensual desires and gratification, by the desire of Knowledge, by the desire of other things…He become so marred, that it is difficult at times to trace God's image in him at all…"*[17] But salvation and regeneration were possible. When a man became a Christian, his characteristics remained the same, but his aims altered. Although an individual could only represent a "marred" image of Christ at best, it was possible for everyone to strive to glorify God in their individual lives. The term "Sensual desires" when used by Laws implied a psychological or neurological explanation of the nature of sin. For Laws, Satan operated, directly or indirectly, *"through our passions, through our evil desires or lusts…"*[18]

In a sermon based on I Kings XIX Laws developed this psychological reading of the Bible, demonstrating again how natural and spiritual knowledge were reconcilable. He analysed Elijah's character and temperament, his condition and "mental attitude":

> ...in all probability [Elijah] was a man of a very fervid yea even perfervid temperament, that he would soon on the lofty heights of imagination of daring, of action, but that following immediately on this there would come reaction. The nervous strain which he had undergone left him weak and almost helpless...

In the cave, God's angel came to support Elijah's body and mind:

> To give him assurance that God was with him… to make him sleep. to recover in rest, that nervous power which was then throbbing so low. Perhaps it may be said, this is a very materialistic view to take of the matter...this is quite true. I am explaining on simple natural grounds what I believe to be the real side of his case...Elijah was a man of like passions with ours of like bodily nature and temperament with us, and here it is shown and God does not find fault with him for

[16] Cheyne 1983, pp. 137-139. For missionary as a male role, see Bowie 1993, p. 1. Laws' attitude can be understood as part of a long-standing tradition of Christian androcentricism. Willi Braun has linked the early Christian commitment to "manliness" to "hegemonic Graeco-Roman gender ideology". In ancient physiological and medical thought, human bodies were understood in a male–female axis of value, with excellence, courage, self-control and strength located at the masculine end of the axis and their binary opposites at the female end. Braun 2002, pp. 108-116.

[17] Sermon XXVI, 8 July 1883. MNA 47/LIM/4/11.

[18] Sermon II, 14 January 1883. MNA 47/LIM/4/11.

> it, but pitying his weakness He restores his strength and tone to his mind which had fallen low...

The lesson of the sermon was apparent when Laws drew comparisons with missionary experiences of fever and healing. In times of need, God, through the Holy Spirit, would restore nervous power, strength and "tone" to missionaries who heeded the advice of both the Word and the book of nature.[19]

Both Laws and Henry Drummond were concerned with science and religion, the book of nature and the Word of God. Like Drummond, Laws believed that both the spiritual and the physical spheres of the world operated according to a set of rules and laws. He was perhaps not prepared to state these laws in such a strident manner as Drummond, as natural laws in the spiritual world. Laws stressed that both science and theology were imperfect and that more work was required in both disciplines in order to approach the truth. However, the concept of energy clearly linked both the material and spiritual spheres in Laws' thinking. For example, Laws believed that when people were endowed with God's saving faith, they could accomplish mighty physical deeds. He compared the influence of religious spirit in the body of man with the experience of people who *"survived wounds that would kill a dozen men"*. In such cases, the spirit was *"putting forth its energy"*, enhancing the physical capacities of men.[20] The spiritual influenced the physical through energy, and in the case of physical illness, and a lack of energy, the reverse could also be the case.

Laws also believed that the healing miracles of Christ were based on the faith of the patients or their loved ones. He discussed healing and faith with care, arguing that,

> … sometimes we see the faith working in the individual… faith which is a living power trusting in Christ… Faith at times which is mingled, even with superstition, but when the superstition is generally chided the faith is being supported and strengthened by Christ's commendation and by its bearing fruit in the miracle wrought.[21]

Laws, the missionary doctor to whom "superstitions" were an enemy, had to be careful in this discussion of faith and physical healing. He condemned fanaticism and "credulity" of all kinds. However, he had reached a compromise allowing, in theory, a justification of faith healing, while simultaneously he stressed the need for "chiding" the superstitious elements from pure and true faith.[22]

Apart from energy and nervous-power, one key concept in Laws' thought about mental and moral health was will-power. He considered alcohol and

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19 Ibid.

20 Sermon XXVIII, 29 July 1883. MNA 47/LIM/4/11.

21 Ibid.

22 Sermon VII, 18 February 1883. MNA 47/LIM/4/11. On the prayer question in Victorian thought, see Opp 2000. On prayer and healing in late nineteenth-century American Presbyterianism, see Smylie 1986, p. 221.

narcotics to be poisons because they weakened the will.[23] Narcotics paralysed and disabled the conscience, will and mental faculties of an individual, preventing him or her from realising their sins and seeking redemption and regeneration. A revealing anecdote in Alexander Hetherwick's biography further highlights the centrality of will power to Laws' generation of educated missionaries. In 1883, when Drummond was visiting Livingstonia, Hetherwick witnessed a struggle of "will-power" between Drummond and Laws. Drummond tried to hypnotise Laws, but "for once he had encountered a will-power stronger than his own."[24]

One of the main perceived dangers to mental and moral health was sexual desire, which could be controlled through the exercise of will-power. In 1912, in a letter to the Governor of Nyasaland, Laws argued that as a doctor he was more qualified than an ordinary missionary to analyse the fundamental causes of sexual immorality: "*at the bottom of all sexual immorality lies sexual desire and the lack of self control which leads to its illegitimate exercise.*"[25]

Energy, will-power and nervous-power linked the physical and the spiritual side of man, physiologically in the brain and the nerves, and spiritually in the soul. They kept dangerous passions and desires, as well as man's general temperament, in check. Strengthening and conserving energy and power were the cornerstones of a healthy Christian life, and were especially important for missionaries in Africa with its particular dangers to both body and mind. Furthermore, mental and moral health, purity and strength were crucial for the Christian converts and missionary pupils who were to become, in turn, as Christ-like as possible under missionary guidance.[26]

7.2 "Diagnosis" – missionary perceptions of Malawian people and societies

In 1875, during his first journey up the Zambezi, Laws commented with admiration upon the "*athletic frames and well developed muscles* [which] *tell of great strength*" of healthy African men on the river, but continued that when suffering from illness their need for "the blessings of the gospel" was apparent,

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23 It is revealing that in the late 1920s Laws wrote that sin in Western society was fashionably "camouflaged" by "heredity, environment, inferiority complex, or any other of the fashionable narcotics of the conscience" Laws in Tilsey 1929, p. vi. For alcohol, nerves and will, cf. Cross 1897, pp. 69-71.

24 Livingstone 1931, p. 32.

25 Laws to H.E. the Governor of Nyasaland 27 February 1912. MNA 47/LIM/1/1/13, 845.

26 Ending a letter to a former Livingstonia pupil working in Southern Rhodesia in 1911, Laws wrote: "*Salute all those I know who are near you. We pray for them & desire them to be pure, strong good men seeking to obey God in all things.*" Purity, strength and moral masculinity were, for Laws, crucial features of the ideal healthy African Christian man facing the dangers and temptations of colonial migrant labour. Laws to Eliya Foti Msuku, n.d. [1911]. MNA 47/LIM/1/1/13, 192.

explicitly linking bodily health to evangelism.[27] It was typical of colonial commentators to admire the physical strength of Africans, although this was often accompanied by a criticism of co-ordination, speed or control of the body. The physical strength, vitality and survival capacity of Africans were admired by the same writers who described them as culturally backward. Among the relatively few African practices that missionaries regarded as "healthy" were tug-of-war and similar physical contests. As Cairns has noted, European pioneers in South-Central Africa admired masculine strength, life force and energy, qualities deemed crucial for their own survival and respected those African groups that seemed to possess such qualities, notably the Ngoni. Colonial narratives typically generalised about Africans and classified them into groups, while ignoring differences between individuals. For their part, the Ngoni shared European admiration of military and martial peoples, and tended to regard non-military peoples as being cowardly and inferior.[28]

After visiting the village of Chikuse, the Southern Ngoni paramount, in 1878, Laws wrote: *"Owing to the cold, bracing climate, the people are lithe and active; the young men going...about the village with the agility of wild cats."* During the same journey, Laws approvingly described the people of Yao chief Mpemba, from the west of Cape Maclear, as *"having a good deal of energy"*, evident from their long-range trading expeditions. During his first visit to Northern Ngoni, Laws expressed his admiration of the co-ordinated moves of the Ngoni warriors and their dancing. In comparison, in his view, the lakeshore people were lacking in co-ordinated movement.[29]

The clothing worn by Africans, martial or peaceful, during the first encounters was, for Laws, a crucial measurement of their civilization. Upon meeting with the Ngonde at the north end of the Lake Malawi in 1877, Laws believed that they were *"the most savage and degraded type of African"* he had seen. Although he recognised that the people were pastoral and had well-built huts, the men's nakedness led him to conclude that *"They are like overgrown children but with the passions and power of men unchecked by any moral influence."* Nakedness signified a lack of moral control and unchecked sexuality for many Victorian commentators on Africa. Stewart, however, held a different view, stressing how well Ngonde women (who were dressed) appeared to be cared for, and praised the masculine attitude of the men, who were warriors, not porters.[30]

"Cleanliness" was a major requirement of missionaries attempting to transform Africans and their societies. From the time of his arrival at Cape Maclear, Laws regularly lectured to African labourers on hygiene, cleanliness and order. In W.P. Livingstone's words, "With their ideas and habits he was

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27 Laws, letter written at the Kongoni mouth of the Zambezi River, Aug. 1875. AUL, M/Laws 3/1, Transcripts of letters from Robert Laws.

28 *The Livingstonia News*, February 1911, pp. 22-23; Cairns 1965, pp. 114-115, 190; Rau 1979, p. 137. "Martial races" were first categorised by the British in India after the Mutiny of 1857, see Hall 2004, pp. 74-75.

29 Laws 1879; Livingstone 1921, p. 163.

30 Laws, quoted in Livingstone 1921, p. 129; Stewart 1879, p. 297.

perpetually at war and was concerned to train them in tidiness and cleanliness. Anything done wrong he would make them do over again." Those who were employed by missionaries were trained rigorously (usually by missionary wives) in domestic hygiene. As the first school monitors at Cape Maclear "advanced", they used their wages to first buy clothes, then soap, a quilt and a blanket. Thus, employing mission workers was seen to lead to a clean, clothed, and eventually Christian population.[31]

The missionary narratives frequently connected the physical and the moral in their descriptions of African people and societies. Donald Fraser's first report on the Senga villages, which he visited in 1898, is an outstanding example of this:

> … they have built their villages amid unhealthy swamps, their physical surroundings showing their need of amelioration. When, however, we turn from the physical side, bad as this is, and consider their spiritual condition, their utter ignorance of true God, of his way of salvation, and their contentedness with their polluted lives and delight in evil, then their need is appalling.[32]

Fraser described the Senga villages and their inhabitants in 1899: "*there the people sit, many of them full of sores, knowing no remedy for their disease, craven, ignorant, spiritless, except when they have made themselves drunk with their strong beer.*"[33] Laws compared the need to take the mission to the Senga with the need to awaken a man lying in snow, sinking deeper into torpor, sleep, and death.[34]

In 1907, Dr Brown wrote from Serenje (Chitambo) in Northern Rhodesia, where he had recently arrived:

> Both Awisa and Alata, among whom our lot is cast, seem in the past to have been at the mercy of Arab, Wemba, and Angoni, and the effects of raids and persecutions of these tribes is seen in the physical and moral condition of the people.[35]

Like Fraser's description of the Senga, Brown's account linked war, conquest and victimisation with the adverse moral and physical condition of the people. Pity was mixed with disgust in these images. Laws explained the perceived weaknesses of the Tonga "character" as being the result of their misfortunes under Ngoni raiding. In contrast, the missionaries had more mixed feelings about the Ngoni conquerors. Despite their violent raids, the Ngoni were generally held to be morally and physically superior to the subordinate peoples. Fraser believed that Ngoni children were strengthened by a "healthy life in the

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31 Livingstone 1921, pp. 95, 180. Laws used similar procedure in the Khondowe plateau during the construction of the Institution. The workers were paid in cloth and in soap, which attracted the local Phoka (Tumbuka) villagers, who were generally suspicious of missionary educational and medical incentives. Oral testimony, D.M.M., 9 July 2004. Cf. Comaroff and Comaroff 1991; 1992; 1997.

32 *The Aurora*, December 1898, pp. 41-42.

33 Fraser to Smith 15 November 1899. NLS, Acc. 7548 D 69, Letters to the Livingstonia Sub-Committee, 1898-1900, 92.

34 *The Aurora*, December 1898, pp. 41-42.

35 Brown 4 October 1907. NLS, Acc. 7548, D 71, Letters to the Sub-Committee, 1907, pp. 97-99.

bush" and the "bracing air", in contrast to the unhealthy conditions in the Senga villages.[36]

However, in some respects, missionary perceptions of indigenous African societies varied and changed considerably over time. It was typical of the missionaries at a new station to at first represent the people as being desperately in need of the Gospel, education, civilization and regeneration, and later amend their views somewhat and discuss positive aspects of local ways of life. The missionaries' understanding of the societies around them developed slowly over time. It was typical that, eventually, missionaries came to regard the particular people that they were settled amongst in higher esteem than neighbouring societies. Furthermore, after the missionaries had settled in a particular station, they jealously guarded the reputation of the Africans within their sphere of influence and would react strongly if other missionaries made negative comments about villages in their area. Criticism of a village could (and often was) interpreted as being criticism of the resident missionaries.[37]

The missionaries' views were often influenced by their African associates. Fraser's narratives describing the Senga villages, for example, were informed by the Ngoni evangelists and teachers who had worked in the region for some months before Fraser's first short visit. One of them was a prominent ex-raider and nephew of the paramount.[38] Their portrayal of the unconverted Senga as ignorant, heathen and unclean arguably combined the prevalent Ngoni attitudes of superiority towards the non-Ngoni groups with the new, Christian sense of superiority over unbelievers. Thus, Ngoni Christians adopted and used elements of the missionary language of derision for their own purposes and, in turn, influenced the missionary's perceptions.

Laws (in contrast to his younger colleagues who generally settled in one or two areas) first worked among the Mang'anja and Yao for six years, then among the Tonga between 1881 and 1891, and from 1894 to his retirement in 1927, in the Khondowe plateau, where the local population were the Phoka (Tumbuka). There, Laws worked primarily with the pupils, apprentices and employees of the Institution, from the Tonga, the Tumbuka, the Ngoni, the Ngonde, and other peoples of the Northern Malawi region and beyond.[39] By the turn of the century, he had become a missionary authority on the comparative ethnography of the peoples of the region.

At a missionary conference in 1904, in a discussion of "How to meet heathen practices", Laws presented a historical overview of the peoples of the Protectorate. He argued that upon his arrival in the region, the ruling "tribes" were those who observed the fifth and the seventh commandments, while those who neglected these commandments were "on the down grade". The code of

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36 *FCSMR* May 1886, p. 138; Fraser to Smith 15 November 1899. NLS, Acc. 7548 D 69, Letters to the Livingstonia Sub-Committee, 1898-1900, 92; Livingstone 1921, p. 205.

37 For the missionaries' political identification with the peoples with whom they worked, see McCracken 2000, pp. 211-213. See also Sinclair 2002, n296.

38 Fraser to Smith 15 November 1899. NLS, Acc. 7548 D 69, Letters to the Livingstonia Sub-Committee, 1898-1900, 92; Livingstone 1921, pp. 317-318.

39 Livingstone 1921; McIntosh 1993, p. 149.

morality differed: while among the Ngoni adultery was punished by death, Laws held that in Tongaland *"social purity was...almost unknown."*[40]

Laws insisted that the missionary *"must not be an iconoclast"*. Instead, the customs and beliefs of Africans should be understood and utilised, if possible, for the missionary purposes of conversion. He held that the "influence and personality" of an individual missionary were crucial in "raising and elevating" Africans. For Laws, the Northern Ngoni were comparatively "uncivilized", yet more trustworthy than other "tribes", and he argued that he would *"far rather be responsible to the Government"* for them than for some of the European colonialists in positions of power.[41] The paternal missionary authority, taking responsibility for "trustworthy tribes", was never questioned, of course.

By this time, Laws' understanding of local societies had developed allowing him to recognise the value of the traditional moral order. Laws held that until Christianity based on the Holy Spirit established a new moral order, society was in turmoil and missionaries needed to exercise patience and understanding. In theory, his ideas of an anthropological study of African societies followed by the Christianisation of suitable customs and practices were comparable to the ideas of some of his younger colleagues, notably Donald Fraser and Thomas Cullen Young. The admiration of Ngoni morality was a salient feature of missionary narratives. By the early 1900s, missionaries increasingly viewed the moral health and well-being of local societies as being threatened by changes wrought by "civilization" and colonialism. Nevertheless, as late as 1918, Prentice described pre-colonial and pre-Christian Central Africa in the familiar language of evolution and regression:

> There was no process of evolution going on, but rather a process of disintegration...So, too, in the religious sphere, the people were probably on the down grade. Socially, intellectually, morally, they were on the down grade, and there was no power in the land to arrest the process of decay. But Christianity came in, and took the people by the hand, and they were being led up to a higher standard of life than they ever before knew.[42]

In his assessment of the effect of ten years of missionary work in Mwenzo between 1899 and 1909, James Chisholm described the mental, physical and moral condition of the people at the time of his arrival:

> Their knowledge of spiritual things was an Egyptian darkness made visible by sacrifices and superstitions, their mental equipment was limited to knowledge acquired in the maintaining of a human life under the most primitive conditions, and their care of the body and its environment was such that one wondered how even so many remained to testify to the law of the survival of the fittest…[43]

To Chisholm, the results of a missionary presence in Mwenzo were the rejection of "evil practices", the lessening of "superstition" and fear, and the fostering of

40 *Report of the Second General Missionary Conference*, 1904, pp. 18-20.
41 Ibid.
42 Speech of George Prentice, *Proceedings and Debates of the General Assembly of the United Free Church of Scotland 1918, May 23.*
43 *Annual Report of the Livingstonia Mission 1909*, p. 46.

a "brighter and nobler outlook upon life". At an individual level, Chisholm witnessed the effects of moral progress through physical changes, which were apparent especially in the elderly. In theory, such a transformation might be sudden, total and dramatic. However, Livingstonia missionaries generally, and particularly Laws, believed in slow, gradual transformation.[44]

By far the most negative image of a "degenerate" people in the Livingstonia missionary narratives was that of the "Arabs". They were also blamed for the plight of the Africans, but unlike the Ngoni they were not admired in any way. Instead, in addition to the raids and slave trade, they were explicitly blamed for the spread of venereal disease and sexual immorality. "Arab disease" was one of the missionary terms for syphilis. The "Arab slave trader" became the arch-enemy of the medical missionary in missionary chronicles, particularly during the "Arab war" of 1887–88 when Cross was a military surgeon in the European expedition against Mlozi's forces. Cross believed that whenever African people came in contact with Arabs, they would "degenerate" and become "*doubly as hard to influence for good*". This demonisation of Arabs was useful in missionary propaganda. As the conversion of Muslims was not a missionary priority, the missionaries had little need to understand Muslims or to write positively about them. As Cairns has noted late Victorian missionaries in East and Central Africa found the conversion of Muslims notably difficult. Mission supporters at home vehemently argued against those who believed that Islam was the truly progressive religion in Africa. Furthermore, intermarriages between Europeans, Arabs and Africans were abhorrent to many late Victorians, who associated inter-racial unisons with racial degeneration, and believed that, in general, "half-castes", inherited "the vices" of both races.[45]

Although the Livingstonia missionaries initially considered Nkhotakhota to be part of their sphere (in 1890 Laws considered sending a medical missionary there), they chose to steer clear of the nearest centre of Islam. The town came to be regarded as the centre of various evils and immoral life, and was possibly beyond redemption. In 1912, Laws held it to be a far more morally dangerous place for Livingstonia pupils than the South African or Rhodesian mines.[46] The coastal region to the east was also held to be particularly dangerous. In 1900, a writer in the *Aurora* warned of degenerative Islamic influences, apparent in young mission-educated men returning from the coast *"wrecked in their moral character, and using the profession of an ignorant, bastard*

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44 Ibid., p. 47; Chisholm, quoted in *FCSMR*, January 1908, p. 24. For physical transformation in Christian women, see Fraser 1901, pp. 28-31. According to W.P. Livingstone, Laws "had little faith in the permanency of sudden, emotional conversion of character – not, at any rate, with a primitive race hardened by ages of habit." Livingstone 1921, p. 246.

45 Cross, quoted in *FCSMR*, December 1896, pp. 294-295; Cairns 1965, pp. 203-212.

46 *The Livingstonia Mission. Lake Nyasa and Uplands, East Central Africa. Five Years' Work – 1886-90;* Laws to H.E. the Governor of Nyasaland 27 February 1912. MNA 47/LIM/1/1/13, 845; Cairns 1965, pp. 213-216. Nkhotakhota was closed to Europeans in early 1890s, and it was generally considered exceedingly unhealthy by Europeans. Nevertheless, the UMCA opened a station there in 1894. Good 2004, p. 275.

Mohammedanism to stifle their consciences and palliate the degradation of their unclean lives."[47]

As Megan Vaughan has noted, colonial medical writers tended to describe perceived differences in disease patterns and the health of African groups in terms of ethnic or "tribal" difference. Medical discourse specified features of ethnic categories, viewing them in an evolutionary scale of advancement or backwardness.[48] This was typical of the missionary perception of African societies in Livingstonia, but it was characteristic of missionary rhetoric and language to first create an image of suffering, backward peoples, and then present a plan for regeneration and holistic healing. The groups that did not fit into this plan, in particular Muslims, were classified as agents of degeneration.

The degenerative impulses

Moral hygiene aimed to prevent impulses of individual and collective degeneration. Some of these impulses were held to be universal, while others were specifically "African" in character. Alcohol and sexual promiscuity were considered to be particularly dangerous to health resulting in alcoholism and increased susceptibility to disease, injury and violence in one case, and venereal disease in the other. Ideas about African sexuality were central to the missionary and colonial medical discourses about Africans, and had a powerful influence upon the European mind in its construction of images of the "other".[49] Alcohol, in contrast, was a particularly familiar problem for the Scottish missionaries.

Alcohol

The Livingstonia missionaries in general absolutely condemned drinking. This attitude stemmed from their experiences in late Victorian Scottish society, where strong drink was viewed as the primary cause of many urban social problems. Laws, Black and Steele, among others, had worked for the home missions in Scottish city slums before their appointment to Livingstonia. [50] The Free Church was closely connected with the Temperance Movement in Scotland. In the Temperance Crusade, which lasted at least until the First World War, the churches and the medical profession joined forces. For example, in 1896, the president of the Free Church Temperance Society's annual meeting was Professor Simpson, President of the Royal College of Physicians and Surgeons. In this meeting, intemperance was denounced as *"one of the great evils*

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47 *The Aurora*, October 1900, p. 48.

48 Vaughan 1991, p. 81 and *passim*; Packard 1993, pp. 277-278.

49 Vaughan 1991; 1992; 1994a.

50 Laws' experiences and attitudes about drink were particularly severe. His biographers describe how the young medical student in the service of the Glasgow Medical Mission had to wrestle with a "drunkard" in order to treat the man's wife and a newborn child. Livingstone 1921, pp. 33-34; McIntosh 1993, pp. 7-8.

of our time – the source of much misery, disease and crime."[51] The advocates of temperance frequently stressed the connections between drinking and disease, and strove to prove that drunkenness would develop into a disease, which destroyed both brain and body. However, from a medical perspective, it was extremely difficult to determine the point at which drinking became a disease. Nevertheless, the medical authorities wholeheartedly confirmed the physiological damage caused by alcohol consumption and agreed that temperance was the first step towards curing the condition. Chronic alcoholism was regarded as a toxic disease of the nervous system.[52]

When the missionaries encountered Africans drinking beer, their initial condemnation was often no less than it would have been when faced with whisky drinking in Glasgow, and this reaction could easily lead to cultural conflict. In January 1876, Laws described a meeting with a local chief on the shores of the lake: *"… medicine was asked for a bad cough and large belly. When told to leave off drinking pombé the mention of the word was enough to bring out at once the drunkard's opposition."*[53] For many Africans, the idea that abstention from beer could be a public health measure was distinctly alien and in some ways even contrary to the local medical culture.

The missionaries did not realise, initially, that beer in South-Central Africa was of variable strength and, furthermore, had a more important and complex role in the life of a community than distilled spirits did in Britain. For Africans, beer could be a foodstuff as well as a drink. It was commonly used as payment for agricultural labour, and it has been argued that in Northern Malawi, hoeing-for-beer parties were the most effective working groups. Beer also had important place in many religious ceremonies, and was offered to the spirits as a sacrifice.[54] These sacrifices were meant to ensure the support and good-will of the spirits, and prevent ancestral wrath from causing misfortune and illness. Thus, beer was part of the local system of public health, and an all-out assault on beer-drinking and beer-brewing could be regarded as not only depriving people of their food or of an essential part of the agricultural system, but also risked provoking ancestral revenge and causing communal calamities. Had missionaries been aware of this from the time of their arrival they would arguably have had all the more reason to attack brewing and drinking in an attempt to eradicate an unhealthy practice connected to a condemnable pagan religion. However, it appears that the missionaries' condemnation of beer was primarily a reaction based on their own backgrounds rather than an understanding of the functions of beer within local societies. Furthermore, not all missionaries were as extreme in their views as Laws, and even he may have tolerated the consumption of beer in certain circumstances. Pots of beer were

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51 *FCSMR*, May 1896, p. 121; Drummond and Bulloch 1974, pp. 28-29; Hamilton 1981, pp. 182, 218-220.

52 See, for example, interview of Dr Clouston, *FCSMR*, December 1896, p. 305; Cross 1897, p. 69.

53 Robert Laws Diary Journal entry for 20 January 1876. NLS, MS. 7907.

54 Forster 2003, p. 63; McCracken 2000, p. 298; Mkandawire 1971; Oral testimony, S.M., 12 July 2004.

bartered and given as gifts, and chiefs and headmen would offer beer to their visitors. The pioneer missionaries had to be diplomatic, especially when meeting with powerful chiefs. Drinking chiefs could appear particularly threatening.[55]

The pioneer missionaries were wary of beer in part because of a fear that they themselves would succumb to alcohol. Many European travellers in the region drank both European spirits and African beer, and not all missionaries were total abstainers. The fear of European degeneration in Africa was a fear of alcoholism, demoralisation and debauchery.[56] The missionaries also feared the introduction of distilled spirits to Central Africa, and this was one of the main arguments expounded by Scottish missions, the ALC, and their supporters in Britain, when they vocally opposed Portuguese influence in the Lake Nyasa region, and demanded the establishment of British rule. The Portuguese, apart from being Catholics, were regarded as being sympathetic to the liquor trade.[57] Total abstinence was held by many, including Fred Moir of the ALC, to be the key to robust physical health, which could save lives in the trying African conditions.[58] Prospective missionary candidates for Livingstonia were expected to be total abstainers and this was checked as part of their initial medical examination.

Eventually, the missionaries became aware of some of the differences between African beer and spirits. In 1894, Steele wrote from uNgoni:

> The drinking of utshwara, or native beer, is seldom followed by the beastly intoxication we see at home. Yet...it is… a grave danger to the native Church. A Christian native who has imbibed utshwara loses his distinguished mark and becomes like other natives, noisy and foolish. The difficulty is, they say it is their food, and no doubt it is used to some extent as such. The natives say that the late chief Mombera lived on beer and a little beef… No wonder he died![59]

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55 Livingstone 1921, pp. 66-68; Moir 1924, p. 22. Moir recalled that it was often "under the influence of drink" that the "big Arab chiefs" threatened Europeans; Young 1877, p. 62.

56 See, for example, *The Aurora,* June 1900, pp. 29-32. Hastings has argued that one reason why the late Victorian missionaries did not associate their work with "commerce" but preferred to speak of "industrial" work was the association with liquor trade in Africa. Hastings 1994, p. 288. Physiologically, European degeneration in the tropics was frequently connected to the "sensitive European liver", see Jennings 2002, pp. 243, 248-249. On alcohol and pioneer exploration, see Fabian 2000, pp. 68-71. See also Anderson 1992, pp. 514-515.

57 *FCSMR,* June 1889, pp. 170-171. Laws and Fred Moir were representing Livingstonia and the ALC, at the Berlin Conference in 1884. Moir 1924 [1923], p. 42. Eventually, when the Scramble for Africa was in full swing, the selling of distilled spirits to Africans was prohibited in the British Central Africa Protectorate. Missionaries undoubtedly regarded this as a victory, though how effectively the ban was enforced was a different matter.

58 Moir believed that his recovery from a serious bullet wound in the Arab War without amputation was due to "the great value of health of total abstinence and clean living under the most trying conditions." Moir 1924, p. 145. See also Livingstone 1999. Writing in the secular medical vein in his handbook of travellers in Africa, Cross did not absolutely condemn the consumption of alcohol in the tropics, but argued that it would be better to abstain. He emphasised that in no way was alcohol necessary to maintain health in the tropics, and that it should never be drunk before the work of the day, "with its worry and fatigue" was over. Cross 1897, p. 2.

59 Steele, quoted in *FCSMR* December 1894, p. 285

Drinking caused a loss of discipline and self-control, the crucial elements of moral health. For Steele, African Christians who drank beer fell back into uncivilized paganism. Furthermore, through their behaviour they questioned and challenged the authority and control of their European teachers. As Fields has pointed out, in the Livingstonian missionary mind, the issue of the morality of Africans was synonymous with African acceptance of missionary authority.[60]

Indeed, hostility to missionary activity was frequently associated with beer-drinking. Elmslie reported in 1903 that in many villages where beer was brewed, schools had been closed and the missionaries were not welcome. Furthermore, Elmslie held that drinking not only "let loose forces of evil" in unsupervised communities, but it also undermined Christianity in the eyes of non-Christians, who were quick to point out inconsistencies between preaching and practice, and did not respect beer-drinking Christians. Beer-drinking could also be a form of protest. In 1911, the visits of Watchtower evangelists to the North Nyasa district had been followed by widespread opposition to mission teaching, demonstrated by dancing and beer-drinking.[61]

However, on occasion even leading abstainer-missionaries such as Elmslie were not in a position to refuse beer when it was offered by a powerful chief. According to oral tradition, the paramount chief Yohane Jere, the successor of M'mbelwa, repeatedly demanded that Elmslie should drink beer with him. Elmslie eventually agreed to take a sip of beer, a gesture that was appreciated by the Ngoni. Elmslie believed that beer was poisonous, and complained that he did not like the bitter taste of the drink. He also advocated that the chief and the people should not drink more than a little beer.[62] This narrative of Elmslie sipping beer, humbling himself before the chief and moving from total abstinence to moderation (while also warning against the dangers that beer posed to health) suggests that, in practice, the missionaries compromised and negotiated with local leaders in ways that were never published in the missionary journals.

After the turn of the century, the Livingstonia missionaries saw new dangers caused by alcohol threatening local societies and the budding Christian community. There was an increasing demand for labour in the mines of South Africa and Southern Rhodesia, which concerned the missionaries and the planters of the Protectorate. In their rhetoric, the first and foremost danger to the Africans was the strong drink available in the mining areas. Donald Fraser opposed what he saw as the increasing cultivation of crops for beer. For Fraser, beer-drinking was itself a "great social disease", but rather than employing medical arguments, he opposed beer-drinking mainly on environmental grounds and connected drinking with violence. He recognised the "considerable food properties" of African beer and, while stressing that beer could *"do serious harm to the drunkard"*, acknowledged that it was far less dangerous than spirits in this respect. Fraser called for co-operation between the

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60 Fields 1985.

61 Elmslie, quoted in *FCSMR* March 1903, p. 121; Elmslie 12 December 1906. Acc. 7548 D 71. Letters to the Livingstonia Sub-Committee 1907, p. 14; McCracken 2000, p. 305.

62 Oral testimony, W.C., 13 July 2004.

government and mission, arguing that the cultivation of beer crops would exhaust the soil and the movement of people in the "quest for beer" would remove them from the "elevating influences" of the missionary, administrator and trader.[63] The main danger of beer lay in a loss of control, both in the individual and in the collective. The self-control of missionaries and converts alike was threatened, as was missionary control over the converts, and the converts' influence and control over their families. Total abstinence, as advocated by most Livingstonia missionaries, was seen as essential to the maintenance of health for Europeans and Africans alike. Dr Agnes Fraser argued that the total abstinence of Christian parents contributed to family health.[64]

The idea that beer was a cause of moral and physical retardation, regardless of the increasing recognition of its role in the local diet, remained fixed in the missionary mind at Livingstonia. More significantly, following the first large-scale conversions amongst the Tonga and the Ngoni in the 1890s and 1900s, a strong anti-beer movement emerged from among the African converts. Within the wider population there was strong defence of beer-brewing and beer-drinking as a reaction against the attacks of the missionaries and Christians. The issue of beer-drinking became a flashpoint for conflict in many local communities. Commenting on the Tonga migrations in 1902, Dr Boxer wrote that while the movement of people to smaller villages over a wider area was healthy from a sanitary and hygienic point of view, he believed that the migration was largely prompted by *"… a desire to be rid of the constraint of a fast forming public opinion on the side of right against dancing, drinking, and such evils."*[65]

Furthermore, as Livingstonia expanded its sphere of operations, its strict beer policy appeared to be in direct contrast to the policies of the Catholic missionaries, the German Lutherans and Moravians, or even the Dutch Reformed missionaries. Following the First World War when the Scots had taken over the supervision of congregations in Tanganyika Territory, this issue was put directly to Chisholm by the villagers of Mbozi (thirty miles from Mwenzo): "Our former missionaries did not forbid beer. You suspend Christians who take beer. Why is this?"[66] The Bible provided no clear guidance on the issue. Jesus had turned water to wine, but without fermentation. In the Kasungu district, where Livingstonia and the Dutch Reformed Church competed with the Catholic missions, a popular song of the 1930s commemorated the beer debate from the Catholic perspective:

> Kale, kale, Aprotestanti anatiyenga
> Musamwa moa
> Lero talowa Ecclesia, Lero talowa Ecclesia
> Akatholika

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63 *The Aurora,* June 1900, p. 26; *The Aurora,* June 1902, p. 72; McCracken 2003, pp. 155-174; Mulwafu 2004, p. 306.

64 Fraser 1914, pp. 467-468.

65 *The Aurora,* December 1902, p. 100.

66 *Other Lands,* January 1923, p. 63; McCracken 2000, p. 221; Wright 1971, p. 158.

(In the past, the Protestants tricked us. You must not drink beer. Today we joined the Church. Today we joined the Catholic Church.)[67]

Dancing and sexuality

Beer-drinking and a loss of moral control were seen by the missionaries as major causes of many African "degrading customs". To them, the most abhorrent of these were associated with sexuality. Beer-drinking was frequently mentioned in the context of "obscene dances" at villages.[68] Initiation rites, in particular, were regarded as "abominable", and the female pupils from the mission who had attended them were seen as "polluted" and "tainted". They had lost the physical and moral "cleanliness" that they had achieved through their association with the mission. The missionaries sought to keep the pupils, especially girls, away from the dances. After the turn of the century, however, the missionaries increasingly realised that local dances and rites were important social customs, many of which had performed the very function of maintaining sexual morality. Donald Fraser argued for the creation of morally acceptable Christian initiation dances and rites for the young. Such dances, Fraser argued, would save the Christian children from "contamination of pagan instruction." He held "healthy and clean" dances to be highly valuable in the creation of a joyous atmosphere within a Christian community, but stressed the need for control exercised by trusted Christians.[69]

The perceived danger of dances was, as in the case of drinking, a loss of control of the brain and nerves. Dancing led to immorality through the unhealthy stimulation of sexual instincts, passions and desires. For Laws, drumming and dancing caused dangerous excitement of the nerves and were a threat to both nervous and will-power, resulting in "nervous diseases" in the worst cases. The fear of uncontrolled sexuality, a major threat to Victorian moral order, was intensified by the fear of uncontrolled African sexuality, which featured prominently in colonial thought and discourse.[70]

In 1904, Chisholm described a "general village dance" in the Mwenzo district, a celebration after a woman thought to have been killed by a lion was found alive and well:

> After the excitement aroused by the revulsion of feeling was allowed to escape by the safety valve of a general dance we returned to the village...the excitement was intense, and the dancing, jumping, screaming, and embracing that followed can only be understood by one who knows the volatile African.[71]

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67 Quoted and translated in Linden 1974, pp. 147-148.
68 See, for example, *The Aurora*, December 1899, p. 47.
69 *FCSMR*, September 1890, pp. 268-272; Fraser 1913, pp. 110-117; 1921, pp. 110-112; 1927, pp. 106-107.
70 Laws to Candy 2 May 1903. MNA 47/LIM/1/1/5, 374. Vaughan 1991, pp. 21-22. See also Hyam 1992; Mort 2000.
71 Chisholm to Daly 25 Jan.–10 March 1904. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee 1904, pp. 53-54.

Later in the evening, Chisholm took the opportunity to preach about "Satan going about as a roaring lion", a particularly appropriate theme under the circumstances. He was congratulating himself of the attention and interest shown, but after the prayers,

> … the drums commenced to beat… it was for the "Chikweta", or obscene dance...I thought I would go and see for myself what it meant. In a letter like this I cannot describe what it means. I only stayed a few minutes… but I saw enough to know that these dances are one of the strongest powers the devil has in this country for enslaving the souls of its men and women. Children of all ages were playing about near the drums. It is very sad to think of them being brought up in the sight and sound of such things.[72]

For Chisholm, a Victorian bourgeois doctor, dancing and drumming led to nervous excitement, which posed a threat to manly control. "The volatile African" in his narrative is in opposition to the calm and controlled European, while disciplined prayer is contrasted with the drums of the devil. Drums were often associated with African "darkness" in the missionary mind but they were not entirely condemned in Livingstonia.[73] Gradually, the missionaries adopted a policy of allowing the performance of some dances under supervision, whilst explicitly forbidding others. For example, in 1911, Laws condemned the *"daroba"* or *"dorp"*, a new dance recently introduced from South Africa.[74] In 1926, the employees of the Institution could be dismissed for taking part in *"zoto, dorola, chikweta or other obscene dances"*.[75]

Polygamy

For Laws, monogamy was the cornerstone of a healthy Christian family, the church and of the nation: *"The Christian home, begun by a marriage of a Christian man and a Christian woman, fitted for each other mentally, morally and physically is the nursery of the Church and its purity must be held inviolable."*[76] Although he admitted that the New Testament did not provide specific guidance for dealing with polygamy, Laws argued that Christ trusted in the common sense of Christians to raise a pure church *"from among the impurities of polygamy and heathenism."* Polygamy was regarded to be, above all, a women's question, which could be solved by missionary work among the women and girls. In 1899, the Mission Council ruled that the polygamists and their wives, with the

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72 Ibid., pp. 55-56.

73 McCracken 2000, p. 181; Fraser used drums to call people to church in Loudon, a notable contrast to the Institution, where bell ringing from the tower designed by Laws was the industrial time-keeper. The bell tower of Livingstonia, which is still standing, was erected in 1905. Cf. Comaroff and Comaroff 1992, pp. 275-276, 283.

74 Laws to Resident Magistrate, Chintheche, 16 November 1911. MNA 47/LIM/1/1/13, 638.

75 "Conditions of Employment in the Institution". Overtoun Institution Senatus Minutes 18 November 1926. MNA 47/LIM/3/32: Overtoun Institution Senatus Minute Book, 1910-1931.

76 *The Aurora*, August 1899, pp. 25-27.

exception of the first wives, were excluded from baptism until polygamous unions were dissolved. Following the spread of Christianity, Elmslie was pleased to report that some men had sent away as many as six wives.[77] The missionaries initially paid little attention to the possible adverse social, emotional and physical consequences of the dissolution of marriages.

The missionaries primarily objected to polygamy on biblical grounds. From a medical standpoint, it was even more difficult to oppose polygamy than beer-drinking. However, polygamy was seen to be morally destructive, to lower a woman's status and to be an insurmountable obstacle to a Christian family life, and to the creation of a healthy Christian society. In the early 1900s, Agnes Fraser compiled statistics, which, together with administrative reports, seemed to confirm that infant mortality rates were higher in polygamous families than in Christian families. This became a useful medico-scientific argument which was employed in missionary propaganda.[78]

While missionary medical discourse had significant potential to represent African practices as being unhealthy to the colonial authorities and mission supporters, mission medical practice was regarded as a useful weapon with which to assault African practices that were not directly harmful to physical health. In 1908, Chisholm wrote:

> The old customs about marriage, puberty, and such like die hard, and a young Christian finds it almost impossible to overcome the feelings of the older people in favour of the old practices. But where one of the friends of the intended bride has been a patient treated in the hospital, he makes himself bound to take our side, and makes it easier for the young man to escape the wrath of his own and his bride's parents for refusing to conform with the former customs.[79]

In this case, a former patient was obliged to side with the missionaries' views on debates on marriage practices. Thus, a successful patient–healer relationship aimed to utilise the gratitude and debt of former patients to make them proponents of all the missionary teaching in their family and village groups. After a successful treatment, the sufferer's therapy managers or guardians

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77 Ibid.; Minutes of the Mission Council 6 November 1899. NLS, MS. 7882, 100; Elmslie, quoted in *FCSMR,* December 1896, pp. 294-295.

78 Fraser 1914, pp. 467-468; Fraser 1911, pp. 186-187; Fraser 1927, pp. 105-107. In 1922, Livingstonia missionaries informed the Protectorate Government that, *"It is an observed fact that monogamous marriages are more fertile than polygamous and the children are healthier."* Minutes of the Mission Council, May 1922. MNA 47/LIM/3/17. This view should be contrasted with the argument put forth by some German and British medical mission writers in the early twentieth century, who claimed that missionary maternity work, child welfare and infant dietetics should become a mission priority in order to ensure that children of monogamous families survived in sufficiently large numbers in contrast to large polygamous families. Oliver 1952, p. 211. In contrast, Dr Stannus, the former PMO of Nyasaland, defended polygamy as a "safeguard" against the "evils" caused by large number of unmarried women in society. Undated newspaper cutting of Stannus' lecture to the British Committee of the International Conference on African Children. Rhodes House, Stannus papers, MSS. Afr.s. 476.

79 Chisholm 9 July 1908. NLS, Acc. 7548, D 71, Letters to the Livingstonia Sub-Committee 1908, pp. 127-128.

were, to some extent, obliged to listen to the arguments of the new healers in society.

A polygamous marriage was one of the main reasons for the expulsion of church members throughout this period. The missionaries referred to such events as "relapses" into "heathenism". These marriages were seen to be a threat to the Christian family and society at large, and polygamy was held to be connected to other "unhealthy" practices such as beer-drinking and immoral dancing. Those who lapsed were in danger of degeneration, and the mission wanted to halt this by all available means. From 1912, the mission demanded that African church members marry under the provisions of the new Native Christian Marriage Ordinance, which included a penalty of up to five years in gaol for "relapsing" into polygamy. Many Africans resented this policy and several church members and catechumens continued to marry outside the church.[80]

Venereal disease

Venereal diseases, especially syphilis, held particular significance for missionary doctors because these diseases were explicitly associated with sexual immorality and impurity. For early and mid nineteenth-century doctors and moralists, venereal disease was a prime example of the way in which volition and physical mechanism interacted to cause disease. In theory, the prevention, control and treatment of venereal disease combined the interests of the medical profession and the aims of the evangelical moralists. In practice, as Mort has shown, the issue was more complex and divisive in Victorian and Edwardian Britain.[81]

The pioneer missionaries associated venereal disease in particular with Arabs and the slave trade. This allowed the missionary doctors to be portrayed in missionary propaganda as heroes of medicine and purity, fighting against the immoral Arabs who were spreading degenerative diseases. The missionaries observed that syphilis was rare in some areas, notably in Bandawe, while it was considered to be common not only in the Karonga area, but also in Sengaland.[82] The "Arab disease" thesis was part of the nineteenth-century image of the "lost innocence" of Africans, and lost much of its currency after the establishment of colonial rule. After the Mlozi campaign in 1895, Cross was

80 Fraser 1913, p. 251; McCracken 2000, pp. 238-239.

81 Mort 2000; Rosenberg 1989, p. 189. See also Boyd 1980. As Vaughan has noted, in the colonial medical reports from Nyasaland in the 1910s and 1920s, "venereal disease" was a separate category, based only on the mode of disease transmission. Vaughan 1994, p. 189.

82 Prentice to Smith 20 November 1899. NLS, Acc. 7548 D 69; Fraser, quoted in *FCSMR*, March 1902, pp. 118-120, Fraser to Smith 15 November 1899. NLS, Acc. 7548 D 69, Letters to the Livingstonia Sub-Committee, 1898-1900, 92.

shocked to report that venereal diseases were spreading rapidly among the Africans who had been employed by the British colonial expedition.[83]

After the turn of the century, missionary concern shifted from the "Arab disease" to the perceived moral and physical problems caused by the migration of labour to the South. The absence of men in the villages was believed to cause both concubinage and unfaithfulness.[84] Fraser wrote in 1902 about the effects of the unhealthy atmosphere of the Rhodesian gold mines on the Ngoni: *"...many a poor youth who had been kept clean by the comparative strictness of 'Ngoni morality, returned maimed and broken by the cheapness of sin there."*[85] However, the missionaries were not unanimous in their opinions about labour migration. Prentice argued that the mission should not criticise labour recruitment by the Government for fear of the Administration's wrath, although privately he held that the process was exploitative. Elmslie described, in 1905, how the Ngoni worked profitably in Rhodesia and returned home "unscathed physically and morally". However, with the changes brought about by the colonial economy and colonial rule, missionaries started to regard the old moral order, especially in uNgoni, in a more positive, albeit nostalgic, way.[86]

Colonial medical authorities in the early twentieth century frequently diagnosed as syphilis what would, in retrospect, be diagnosed as yaws, non-venereally transmitted endemic syphilis and other non-venereal diseases, many of them in Vaughan's words, "diseases of poverty rather than promiscuity". This resulted in some very pessimistic assessments being made about the health of the African population, being made by both missionary and secular colonial medical authorities, especially in Uganda.[87] Yaws was identified in Western medicine in 1905. In the 1910s, it was difficult for the Livingstonia doctors, especially those of the older generation, to distinguish between yaws, syphilis and in some cases leprosy.[88]

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83 *Half-yearly Report of Livingstonia Mission Jan-June 1896,* pp. 7-8. Vaughan 1994, pp. 178-179. Livingstone, among others, had believed that a "certain loathsome disease" was not found in "persons of pure African blood". He almost certainly meant syphilis. Livingstone 1857, p. 113. I am grateful for Dr Lesley Hall for helping to interpret this text. (Personal communication from Dr Hall to the author, 14 April 2003). For one, E.D. Young stressed the morality and modesty of the peoples of the lake region, and claimed that "the social evil...is utterly and positively unknown in the land". By social evil, he apparently meant prostitution. Young 1877, pp. 48-49. According to Good, syphilis was "probably a relative late-comer to tropical Africa and was often introduced by Europeans". Good 2004, p. 237.

84 *The Aurora,* February 1900, pp. 11-12.

85 Fraser, quoted in *FCSMR,* March 1902, pp. 118-120.

86 Prentice 27 June 1903. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee 1903, p. 102; *FCSMR,* February 1905, pp. 74-75; *Report of the Second General Missionary Conference,* 1904, pp. 18-20; Young 1931. At this time, relationships with the BSAC were very important to Livingstonia, which may have contributed to the fact that the Blantyre missionaries were much more vocal critics of labour recruitment.

87 Vaughan 1994, pp. 179-185. For the colonial construction of syphilis epidemic, see also Callahan 1997; Kuhanen 2005, pp. 300-305; Vaughan 1992.

88 Good 2004, p. 387. In 1911, for example, Laws wrote of a "puzzling" case with some symptoms that could be explained by yaws, "venereal" or leprosy. In this case, Laws claimed that the African patient explicitly denied that he had yaws. Laws to Innes 24 July 1911. MNA 47/LIM/1/1/13, 430. Good erroneously claims that yaws was not

The missionary doctors rarely described their treatment of syphilis. Before the 1910s, when Salvarsan was introduced in Europe, syphilis was usually treated using mercurial compounds that all had harmful side effects and were, at best, only mildly effective.[89] William Scott recalled a case in the 1880s when a patient being treated with a course of mercury pills gave all of his tablets to his wife with disastrous results. In 1914, Laws prescribed "a usual dose of grey powder" for a syphilis patient, with disappointing results. The patient soon returned severely salivated and Laws put him on a third of the original dose.[90]

After the First World War, more effective arsenical drugs became available, but these were expensive. In 1919, the Livingstonia doctors requested additional resources from the government specifically for their treatment of venereal cases. Salvarsan for intravenous injections, potassium iodide, mercury and surgical equipment were all needed. Effective treatments for syphilis, as well as yaws, were so costly that they were largely beyond the reach of the mission dispensary. Laws made a specific appeal that in the campaigns against syphilis the treatment of yaws should not be overlooked. However, in Nyasaland, colonial medical officers continued to treat African patients with mercurial compounds in the interwar years, a policy which was resented by the people. The lack of effective medication to treat venereal diseases led the missionaries to concentrate largely upon prophylactic methods, in the form of moral education and social engineering. In this respect, they adopted a notably different course from the colonial medical authorities, causing friction between the two groups in the inter-war period.[91]

For Laws, a sexual "lapse" that led to venereal infection was the worst form of moral and physical degeneration that threatened African Christians. In some cases, capable teachers would be dismissed on the grounds of sinful behaviour and would later arrive at the mission hospital as patients.[92] The severe attitude extended from cases of actual venereal infection to a general condemnation of all kinds of sexual misconduct among the Christians. For Laws, a lapsed Christian was "worse than a raw native", and the breaking of the seventh commandment could never be completely forgiven. Laws wrote to a preacher who had been suspended because of adultery:

> It is good that you have repented, but if a man's leg is bit off by a crocodile he may be very sorry that he put his leg into the hole where the crocodile was, but that will not

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confused with syphilis or leprosy in Malawi. Good 2004, p. 237. In the first meeting of the Society of Tropical Medicine in 1907, Patrick Manson stated that *"… the battle is still in progress as to whether yaws is syphilis or an entirely independent disease." Transactions of the Society of Tropical Medicine and Hygiene, Vol. I. 1907-08*, p. 6. The famous Uganda misdiagnosis was made by noted British medical authorities, including Dr Albert Cook of the CMS, and was only corrected by the late 1930s. In all probability the missionary doctors in Livingstonia were aware of reports from Uganda published in medical journals. See Kuhanen 2005, pp. 281-306.

89 Porter 1997, p. 452.

90 Scott 1985, p. 54; Laws to Caverhill 21 January 1914. MNA 47/LIM/1/1/15, 578.

91 Laws to Acting Chief Secretary 31 July 1919. MNA 47/LIM/1/1/19; Vaughan 1994, pp. 183- 196. In UMCA hospitals, new arsenicals to treat yaws were bought, following a successful appeal in Britain in 1920. Good 2004, pp. 387-388.

92 Livingstone 1921, pp. 325-326.

> bring back his leg. The sin you have made may be repented of, but that will not make the people who do not love Christ believe in you or listen to you when you try to teach the Ten Commandements.[93]

Individual forgiveness in Christ was possible, while restoration to a position of authority in the holistic regeneration programme was not. Something in a person had been permanently lost through adultery, comparable to the loss of a limb.

7.3 Moral education and holistic health

Cultivation of character in the Overtoun Institution

In an article written in 1897, setting out the educational policy of Livingstonia, Laws defined education as *"the cultivation of the moral, intellectual and physical powers"*. Moral education, based on the teaching of the Word, was emphasised because without moral progress, there could be no lasting advancement, and the African pupils would "sink back" into "heathenism". Only those mission students who accepted Christian moral values would be useful to the advancement of civilization. For Laws, this was as indisputable as "the use of quinine in the treatment of fever". It was both natural and inevitable that mental and physical advancement would follow on from moral progress. Intellectual faculties would no longer "remain dormant" after spiritual awakening.[94] While moral growth would "invariably" lead to intellectual and physical regeneration, moral degeneration would, equally invariably, lead to intellectual and physical decline. Laws' views on education were based on this assertion, which he held to be confirmed by the teachings of the Bible, science and medicine. The concept of "character" was essential to the Livingstonia programme of "regenerating" Africans through education. The formation of the Christian character involved the total transformation of an individual. The definition of character extended to the physical, mental and spiritual spheres, and beyond race or class. For Laws, character was far more important than the mere "accidents of race, birth or gold".[95]

Obedience and loyalty towards the missionaries were seen as essential elements of the proper character and morality of African pupils at the mission. Character training was an essential part of a hegemonic programme that aimed to create a completely transformed African elite who would consent to missionary control, and in turn transform their villages into true Christian communities. Such Christian conversion was cultural as well as religious, and holistic health had a central place in this conversion. Whilst in Europe moral,

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93 Quoted in ibid., pp. 268, 326.

94 *The Aurora,* April 1897, pp. 9-10. Mental development caused by Christianity was also emphasised by Dr Agnes Fraser; see Fraser 1914, p. 469.

95 Laws to Klamborowski 27 March 1917. MNA 47/LIM/1/1/17, 930. Cf. Lyons 1994, pp. 212-213.

mental and physical education were seen as the preserve of parents and the state, in Central Africa the missionaries considered education to be their responsibility.[96] The moral health of Christian converts and mission pupils had to be secured through constant and vigilant supervision by missionaries. The missionaries were anxious to control sexual behaviour and prevent any intemperance among pupils and thus favoured housing pupils in boarding houses where close supervision was possible.

Those educated at the Overtoun Institution from the mid-1890s onwards came under particular scrutiny. One reason for the Institution's remote location in the Khondowe plateau was to secure European health in the tropics. Additionally, missionary supervision was to protect the moral health of African pupils at the boarding school. The removal of pupils from their home environment was deemed to be crucial to the successful enforcement of missionary control. At the Institution, the pupils and apprentices were cut off from their homes except during the holiday seasons. They were subjected to strict discipline and strenuous studying and physical work and were given very little or no spare time at all. Some forty per cent of the apprentices left the Institution before completing their indentures, which reveals something of the pressures and the discipline apprentices were subjected to.[97]

In 1899 and 1900, while Elmslie was in charge of the Institution during Laws' furlough, concerns were expressed about the moral and physical well-being of the students. Elmslie criticised the prevailing curriculum, which he believed placed too much emphasis upon bookwork. He argued that for half of their day, students should undertake hard, profitable and educational manual labour. The unhygienic housing conditions, particularly in the boys' dormitories, were seen to threaten pupils' moral well-being. Elmslie feared "a good deal of secret sin" was committed in the Institution and following some cases of "immoral conduct", Elmslie argued that the conditions in the dormitories, where two or three boys slept in the same bed, were "against the moral wellbeing of the boys." He held that the sharing of beds, which was done both for warmth and because of lack of room, was, *"In this country and with native tendencies such as they are… very unwise and injurious."*[98]

Elmslie also believed that carpentry and gardening could be effective methods of improving moral health. By July 1900, Elmslie could report that the introduction of three hours of manual work every afternoon had visibly improved the health, habits and "mental vigour" of the pupils. Physical labour was regarded as an effective means of preventing sexual promiscuity, masturbation and homosexuality, as well as being a prophylaxis and cure for mental and physical disease. The new arrangement also lessened the costs of

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96 *The Aurora*, June 1901, p. 14. The process of holistic conversion had its material and immaterial elements, as Fields has noted. Tangibles included imported clothing, cash crops, brick houses, Western medicine, tombstones, books and money. Intangibles included individualism, Western education, nuclear family, middle-class values and virtues, skilled trades, and ambition. Fields 1985, p. 41.

97 *The Aurora*, August 1901, pp. 29-31; McCracken 2000, p. 181.

98 Elmslie to Smith 31 January 1900. NLS, MS. 7883, 14.

education, and epitomised the work ethic that the Scots valued so highly. In addition to practical manual work, drill and, later, team games were introduced at the Institution as a means of maintaining holistic health, as well as contributing to the character training of the pupils.[99]

Nerves and health

The moral and mental health of an individual was based upon their nervous and will-power. Neurotic tendencies were often seen to be the cause of "irrational" or "irresponsible" behaviour. After dismissing a pupil who refused to work in 1911, Laws suspected that the student's refusal was caused by his neurotic tendencies. Conversely, an unwillingness to undertake manual work at the Institution could actually be the underlying cause of mental disorders, such as "mild hypochondria".[100] In the early 1900s, mental illness and epilepsy were of particular concern to missionary doctors in Nyasaland. In 1904 they proposed that the government should establish an asylum to house the many African cases, (such as "the epileptic, the insane and the imbecile") that the missions were unable to cope with adequately.[101]

It is noteworthy that Laws often emphasised the distinction between "temporary" and "permanent" insanity. Mental recovery was usually possible within Laws' theory of holistic health. In spiritual, physical and mental suffering and disorders, healing and regeneration were possible through the use of both spiritual and natural remedies. "Temporary" cases at the Institution would be restrained and sedated. However, the missionaries had no room to house the permanently insane, epileptics and other "incurables" and they would be sent to the government asylum. Thus, the missionaries became important refereeing agents for the colonial asylum.[102]

Nervous disorders could be caused by various "immoral" habits, inherited tendencies, excessive bookwork or insufficient manual work. Laws was hesitant

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99 Elmslie to Smith 11 December 1899. NLS, Acc. 7548 D 69; Elmslie to Smith 24 April and 12 July 1900. NLS, MS. 7883, 35, 112; *Annual Report for 1903*, p. 7. The missionaries referred to sodomy as "uncleanness", and there were investigations of "attempted uncleanness" in the Institution. Laws to MacAlpine and Innes 30 December 1907. MNA 47/LIM/1/1/9, 443. For drill and games, see Hokkanen 2005. In the 1920s, T.C. Young, for one, believed in physical education as suitable form of sublimating sexual desire. Forster 2003, p. 118.

100 Laws to McFarlane 21 September 1911. MNA 47/LIM/1/1/13, 561; Laws to Dr Fisher 18 February 1914. MNA 47/LIM/1/1/15, 627.

101 *The Nyasaland United Missionary Conference: Report of the Second General Missionary Conference,* 1904, p. 29. Epilepsy was frequently connected to "intemperance and insanity in the family" and it was thought it was often triggered by "fright, overwork and great excitement". Cross 1897, pp. 63-64; *Annual Report for 1902*, p. 10.

102 Laws to District Resident, Karonga, 12 July 1916. MNA 47/LIM/1/1/17, 457. Vaughan has noted how, in the 1930s, the fact that a large proportion of the patients in Zomba asylum were mission-educated prompted the secular colonial psychiatrists to suspect that it was mission education itself that was disturbing the mental balance of Africans. It may be argued that by sending former pupils and apprentices to the asylum, the missionaries constructed and "created" insanity in Western terms. Vaughan 1982.

to recommend medicines to "nervous" patients at other stations, but in a case of extreme restlessness, in 1911, he advised that the patient should be given "ten grains of Bromide of Potash, twice or even three times a day" dissolved in water.[103] Work in the open air, involving a minimum of "mental effort" was Laws' preferred therapy for problems caused by "neurotic temperament". As labour was routinely used as a form of discipline at the Institution,[104] it could be difficult for the pupils to make a clear distinction between therapy and punishment. A change of scenery was also prescribed for both Africans and Europeans suffering from a variety of nervous disorders. In the case of two mission girls suffering from a "hysterical outburst" in 1916, Laws planned to send them to Ekwendeni to recover. At the same time, Laws reported a "mental outbreak" at Ngara, possibly connected to beriberi.[105] Another disease that was believed to cause nervous disorders was influenza, as further discussed in Chapter 8. In these cases, a mental disorder was seen to be the direct result of physical disease.

False religious experiences could cause nervous overexcitement, which was a particular danger for prospective Christians. For this reason Donald Fraser emphasised the genuine nature of the Ngoni revival of the late 1890s and early 1900s, stressing that he had checked the unhealthy, "noisy demonstrations" of a hysterical nature. When, during the Convention of 1898, two leading converts in uNgoni, Andrew Mkochi and Daniel Nhlane, had retired to the bush to pray and were in Fraser's opinion in danger of nervous overexcitement, Fraser gave them "good doses of salts" from the dispensary as a nerve tonic and advised them to get a good sleep before discussing religious matters again. The mass revival meetings encouraged by Fraser, particularly Charles Inwood's evangelical campaign of 1910, were viewed with suspicion by some missionaries, including Dr Prentice. Laws had to reassure Prentice in 1913 that he had personally witnessed that the religious atmosphere at Inwood's meetings had been a genuine result of the Holy Spirit, and that when "excitement" had surfaced, Inwood had been the first to put it down. Laws agreed with Prentice that mass meetings at night, where people might be "swayed up by emotion" were not appropriate, and emphasised that the mission had not taken up a policy of "excitement and manifestations".[106] In his

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103 Laws to Mackenzie 29 September 1911. MNA 47/LIM/1/1/13, 575. Cross recommended in 1897 a thirty-grain dose of bromide of potassium twice a day to epileptic cases, claiming it "acts like a charm on the natives", accompanied by a "good tonic" such as Easton's syrup. Cross 1897, p. 64.

104 Laws to Duff April 1915. MNA 47/LIM/1/1/14, 251. Laws had prescribed open-air therapy to Y.Z. Mwasi on occasion at the Institution. In this letter, written in the aftermath of the Chilembwe rising, Laws gives testimony of Mwasi's character and ability, while mentioning his "neurotic temperament" in passing. For work as punishment, see Laws to Superintendent of Native Affairs 19 May 1915. MNA 47 LIM/1/1/16, 446.

105 Laws to Elmslie 31 March 1916. MNA 47/LIM/1/1/17, 203.

106 Fraser 1925, pp. 143-144. According to Fraser, the converts had seen angelic forms and felt their bodies floating about. Fraser compared these experiences to those of the European mystics, and stressed the genuine Christian faith of the converts. For him, while the emotions themselves were not unhealthy, emotional excess was. Laws to Prentice 2 November 1913. MNA 47/LIM/1/1/15, 482. According to his biographer,

own congregation at Kasungu, Prentice dealt sternly with "unhealthy excitement" and "hysteria" among Christians.[107]

Fraser developed an idiosyncratic approach towards nervous health and religion. At a missionary conference in 1910, he suggested that missionaries should utilise the African belief that spirits such as *virombo* caused bodily harm, in order to promote belief in spirits capable of causing spiritual harm, "demons" in a Christian sense. Spirit possession and divination could be interpreted as madness or hysteria. However, for Fraser, the perceived neurotic tendencies of Africans, when correctly channelled and controlled, could contribute to genuine and benevolent African religious experience:

> I know that the African is neurotic, few people can be more so, yet I do not see that we must taboo all neurotic tendencies. If he knows himself to be possessed by God and submits this possession to the test of harmony with the revealed will of God I do not see why this should not be a great asset to the church. It has great dangers, but it has also its great powers. It is not the "canny Scot" but the fervid Celt who is most closely allied to the African…[108]

In this regard, Fraser adopted a very different position from Laws, Elmslie and Prentice: doctors for whom careful nervous control and discipline were essential to health and well-being.[109]

Moral control

The moral control and supervision of the theological and medical students at the Institution was deemed to be of particular importance because these men were seen as the future regenerators of local societies in Laws' scheme. From 1900 onwards, the Livingstonia Presbytery demanded that each theological student's minister should issue an annual certificate testifying to the student's "moral character". The Livingstonia Kirk Session, during the period 1900–10, suspended several pupils and apprentices because of "immoral" or "unclean acts" or "antenuptal fornication". Two church elders, Yuriah Chirwa and Edward Boti Manda, were responsible for the supervision of the Institution dormitories from 1903.[110] Supervision of the pupils was extensive, covering

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Laws personally checked the unhealthy "emotionalism" apparent in sobbing during Inwood's meeting. Livingstone 1921, pp. 343-344. Crying could lead to hysteria and nervous collapse. The Scots generally disapproved of African funeral practices, finding "loud wailing" objectionable. Paradoxically the same writers frequently claimed that Africans lacked sympathy for the sick and dying. "Emotionalism" and "sentimentalism" could, for late Victorians such as Laws and Robert Baden-Powell, also signify erotic feelings. Cf. Jeal 2001, p. 94.

107 *Annual Report for 1913*, p. 28.

108 Fraser, "Heathenism" in *Report of the Third General Missionary Conference of Nyasaland*, 1910, pp. 30-34.

109 In 1924, Mamie Martin noted that Fraser was regarded as a "Celtic visionary and unpractical idealist" by many of his colleagues. Martin 28 January 1924. Sinclair 2002, p. 176.

110 Livingstonia Presbytery Minutes 10 May 1900. MNA 47/LIM/3/21; Session Minutes of the Livingstonia Congregation 6 March, 6 April 1903 and *passim*. MNA

language as well as behaviour. In 1905, a church member was found guilty of writing "unclean letters" to a girl who was also a church member. The session, moderated by Laws, concluded that the "horrible" language in the letters *"could even spoil the mind of a reader."*[111] Although, apparently, no actual "wrong" was done, the writer was suspended and the girl was forbidden to attend communion. Thinking or writing about sex prior to marriage was "unclean" and could pollute the mind.

"Immorality", "obscene dances" and the consumption, production or sale of intoxicants were listed, 1926, as grounds for dismissal from Institution employment. Furthermore, any casual labourer exerting an unspecified "evil influence" could be dismissed instantly. During that year, thirty "capitaos" were dismissed for a variety of reasons.[112]

While the missionaries, doctors as well as laymen, in Livingstonia were gravely concerned about the degenerative effects of alcohol, sex and other nervous excitement, their theories of degeneration and regeneration differed significantly from the pessimism of contemporary secular psychiatry. Missionaries sincerely believed that African regeneration through religious conversion was possible in most cases. It is telling that Laws preferred the term "unregenerate" to "degenerate", and that Cross linked degeneration to "Arabs" but not to "Africans". The fact that in some cases the missionaries sought to restore the suspended church members who had "lapsed" into drinking, dancing or sexual "immorality" suggests that moral illnesses were held to be curable. However, the restoration policies of individual missionaries varied, and it has been noted that Donald Fraser, for example, preferred a much shorter period of suspension than the medically-trained Laws and Elmslie. Furthermore, in some cases restoration of church membership never took place. For example, in 1908 the Mission Council headed by Elmslie announced the final suspension from theological classes of Thomas Rufu, a former student expelled in 1900 for sexual "immorality".[113] Final suspension, whether from church membership or from mission education, effectively marked that person as tainted and unclean, as someone who could have no place in the healthy Christian community.

47/LIM/1/3/16. Yuriah Chirwa was an especially influential figure at the Institution. Until the early 1920s, he was Laws' main assistant and informant on events and practices in the region. On Chirwa, see Mkandawire 2003.

111 Session Minutes of the Livingstonia Congregation 9 August 1905. MNA 47/LIM/1/3/16.

112 Overtoun Institution Senatus Minutes 18 and 29 November 1926. MNA 47/LIM/3/32.

113 Minutes of the Mission Council September 1908. NLS, Acc. 7548 D 71. Letters to the Livingstonia Sub-Committee 1908, p. 146. Cf. Pick 1989.

7.4 Creating a healthy society

Women, children and family

The education of girls and women was considered to be crucial to the creation of a morally and physically healthy Christian family, which was in itself a precondition for the healthy society. Laws believed that the *"Christian life of a community may be fairly gauged by the condition of the homes composing it."*[114] Consequently, the curriculum for girls at Livingstonia emphasised sewing, washing, ironing and household work as well as Bible study. In this respect, Livingstonia was a very orthodox Victorian mission. The broad aim of female education was to produce morally, mentally and physically pure Christian wives and mothers, who would complement and assist virtuous Christian men. As Gaitskell has pointed out, before the 1910s, this was the predominant pattern of missionary education in South Africa: in educational centres such as Lovedale, the objective was to provide domestic "model wives in transformed Christian households" who would be support personnel for the church. The prevalent missionary assertion was that without any available Christian wives, the male converts would be lost to the church. Lovedale, where Stewart and Waterston played crucial roles, was a major influence on Livingstonia. At the turn of the century, when the number of Christian converts was increasing rapidly within the mission, the missionaries in Livingstonia began to demand that Christians should only marry other Christians. Any Christian marrying in a "heathen" tradition could face the suspension of their church membership or delayed baptism.[115]

Boarding schools for girls were established early in the history of the mission stations, and were supervised by pioneer missionary wives including Mrs Laws and Mrs Henry. Scrupulous physical cleanliness was the initial requirement of mission schoolgirls. In 1890 in the Livlezi valley, Mrs Henry demanded that her pupils bathe in the river every morning before entering the school. The same principles were introduced at the Institution, which in the cold conditions almost provoked a rebellion in 1897, when the Ngoni girl pupils refused to take their compulsory morning bath. A compromise was reached and the girls were permitted to start their day half an hour later in the cold weather. After cleanliness, the next priority at the schools was to eradicate nakedness among the girls. Pupils were taught to sew their own dresses. During these sewing classes, Mrs Henry spoke to the girls about proper "modesty": *"I tell them we want to teach them to wear dresses always; that if they were in our country as they are here, they would be put in prison. They look perfectly amazed."*[116]

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114 *The Aurora,* December 1897, p. 41.

115 *The Aurora,* August 1899, pp. 25-27, *FCSMR,* September 1890, pp. 268-272; Bowie 1993, p. 13; Gaitskell 1994, p. 112-118.

116 *FCSMR,* September 1890, pp. 268-272; *FCSMR,* December 1899, pp. 365-366. McIntosh 1993, p. 149. For Mrs Laws in Bandawe, it was essential to teach the girl-pupils personal cleanliness first. Livingstone 1921, p. 190. Mrs Laws had a notable

The importance of needlework to the missionary project of female domesticity has been highlighted by the Comaroffs and Gaitskell. For the sake of their moral health, the mission girls had to be clothed, made to feel the necessity of being clothed, and taught that being naked was shameful, and, as part of this process, they had to be separated from their naked heathen friends. However, while decent clothing was essential for reasons of morality and health, too many clothes or clothing of the wrong sort was also condemned by the missionary doctors.[117]

After the establishment of the Institution, the mission started to employ single European women as nurses and teachers. For nurse-teacher Margaret McCallum, only a missionary woman could truly enter an African woman's life. She argued that the importance of women in African society had not been adequately recognised: *"The mothers are* *the* *power here.* [emphasis original] *The children care nothing for their fathers, and seldom mention them. To their mothers they always turn for advice and sympathy. In council the voice of the chief's mother has much more weight than the voice of the young chief."* [118] The transformation of women was of paramount importance. The aim of the Institution boarding school for girls was *"the making of strong, true women. There has to be eradication as well as education… there is a great opening for the highest calling the future mother can have in this land, i.e. nursing…"*[119] Training in nursing skills and midwifery was, from early on, viewed to be a key method of reducing infant mortality in the villages, which became an increasingly important issue of public health for missionaries in the early twentieth century. In missionary propaganda, infant mortality was explicitly linked to "heathenism".[120]

African women were often seen to be lacking in their nursing skills and instincts, a "natural" sphere for women in late Victorian society.[121] McCallum wrote in 1899, after receiving a request from a woman to help her friend that this was: *"… an advance from the time, not yet many years distant, when the sick were thrown into the bush to die…"*[122] McCallum, who had been in the country for less than two years, presented an idea of historical progress in her image of African women who were undeveloped in their care of the sick. It was typical of medical missionary writings to present "the African" as initially incapable of feeling sympathy for those who were suffering, an inadequacy that could only be remedied by conversion to Christianity. Both through example and

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reputation for strictness among Africans in Livingstonia, particularly in the training of "house-boys" and was known as *Nyakalaunjuchi* – "as stingily as a bee". McIntosh 1993, p. 191.

117 Comaroff, Jean, quoted in Gaitskell 1994, p. 119. See also Comaroff and Comaroff 1991; 1997. At the turn of the century, Prentice wrote that one reason for the more frequent occurrence of "chest diseases" in Bandawe was the adoption of European-style clothing. Prentice to Smith 21 November 1899. NLS, Acc. 7548 D 69; Thomas 2000, p. 306.

118 McCallum to Smith 18 January 1899. NLS, Acc. 7548 D 69, Letters to the Livingstonia Sub-Committee, 1898-1900, 83.

119 McCallum, quoted in *The Aurora*, February 1900, p. 10.

120 See, for example, *Annual Report for 1903*, p. 17.

121 MacDonald 2000, p. 8.

122 McCallum to Smith 9 August 1899. NLS, Acc. 7548 D 69, Letters to the Livingstonia Sub-Committee, 1898-1900, 89.

demonstration, missionary women would inspire and teach African women to act with sympathy and charity toward the sick. Jessie Fiddes believed that the demonstration of sympathy meant, "planting the Christ in the consciousness" of African women. In the course of their treatment of babies and children, the nurses aimed to establish contacts and relationships with their mothers.[123]

At the Institution, a teacher would (ideally) keep her pupils under personal supervision both day and night, and through constant demonstration set a good example to the girls. Laws argued that only thus

> ...are habits of order, cleanliness and neatness, and Christian character, with God's blessing, likely to be formed. I do not undervalue intellectual acquirements for the women… but all such intellectual advance requires to be balanced… by methodical habits of industrial work done for Christ's sake in a Christ-like way.[124]

Laws held that the girl-boarders should sleep in the same building as their teachers and should be kept behind locked doors at night, a view that was in all probability shared by Mrs Laws. In the early 1900s, however, this view conflicted with the younger missionaries' argument that European nurses and teachers should live separately from African patients and pupils, for the sake of hygiene.[125] In this regard, supervision of the African moral hygiene conflicted with the requirements of European physical hygiene.

For both medical and lay missionaries, uneducated mothers and grandmothers were the "worst enemies" of their children, for physical as well as moral reasons. Their importance as therapy managers was sometimes acknowledged, and it was believed that the old women were particularly hostile to mission therapy.[126] Nurses and doctors frequently wrote about "ignorant" mothers who endangered their children through neglect, improper or inadequate feeding and clothing. Agnes Fraser accused mothers who carried their babies on their backs of initially causing their children to sweat and consequently to become chilled, with potentially deadly consequences. The feeding of gruel to a newborn was considered particularly dangerous. Elderly women, in turn, were accused of corrupting the children through their instigation of "immoral" and "obscene" dances (usually a reference to initiation rites). Village midwives were deemed particularly objectionable and were increasingly condemned and vilified by both medical missionaries and colonial medical officers during the inter-war years.[127]

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123 Fiddes 11 May 1905. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1905, p. 66; Fiddes 16 September 1907 NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1907, pp. 87-90.

124 Laws 26 January 1904. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee 1904, pp.62-64.

125 Laws to Innes 1 May 1911. MNA 47/LIM/1/1/13, 310; for the debate over European nurses' quarters in the DGMH, see Chapter 10.

126 See, for example, Turner, quoted in *The Livingstonia News*, April 1910, pp. 25-26; Brown 10 December 1906. Acc. 7548 D 71. Letters to the Livingstonia Sub-Committee 1907, p. 10; *Report of the Second General Missionary Conference*,1904, p. 63. Cf. Vaughan 1991, pp. 66-69.

127 *Report of the Second General Missionary Conference*, 1904, p. 72; Stuart (neé McCallum) July 1906. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1906, pp.

However, the sexual desires of men, both African and European, were also seen as a major danger for African women. In his letter to the Governor in 1912, Laws placed the responsibility for uncontrolled sexual desires, rape and exploitation firmly upon men, citing examples from South Africa. In his emphasis on the dangers of male sexuality, Laws can be understood in the context of the late Victorian social purity movement in Britain. His arguments closely resemble the ideas of the feminist social purists of the 1880s, and are in marked contrast to European writers who theorised about the sexual passions caused by hot climates and uncontrolled female "native" sexuality.[128] However, explicit mention of the dangers that colonial immorality could pose to African women – their sexual exploitation by the whites – was impossible in missionary publications, unlike the frequent references to the dangers of the "heathen" society.

In the early 1900s, the Frasers argued that despite the attention given to missionary work among African women in Livingstonia, not much had been accomplished in practice. From 1901 onwards, a distinct group of woman elders, *balalakazi* (organised by Donald Fraser) assumed responsibility for the spiritual oversight of female Christians in uNgoni, a policy which was unique in the mission. Fraser argued that the future of Christian families and the "whole life of the Church" depended upon the "character" and skills of women, who needed to be taught about proper "home life", basic nursing and childcare, as well as the "sweet attractiveness of Jesus".[129]

In 1910, Fraser reported that in Loudon, a large and organised women's programme had been launched. A selected group of girl-boarders received daily attention, Mrs Fraser conducted regular "Mothers Prayer Meetings" each Sabbath, and visits to villages included both Bible lessons and practical lessons on the care of the sick. It is probable that Agnes Fraser was in fact the *primus motor* in this initiative to improve women's moral and physical health education.[130] In 1912, the Livingstonia missionaries planned an organised house-to-house visitation system that aimed to bring the missionaries into direct personal contact with the home life of African women. Merely providing Bible classes was not enough. Lessons on *"… health – the care of the body, the feeding of children – their moral training, and simple lessons on cooking"* were all required. Through moral education, the missionaries aimed to eradicate "impure" influences such as indecent dancing, unacceptable sexual practices

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108-109; McCallum to Smith 18 January 1899. NLS, Acc. 7548 D 69, Letters to the Livingstonia Sub-Committee, 1898-1900, 83; Good 2004, p. 349; Vaughan 1994, pp. 193-196.

128 Laws to H.E. the Governor of Nyasaland 27 February 1912. MNA 47/LIM/1/1/13, 845; Mort 2000, pp. 86-100 and *passim*; Hyam 1992; In a commonly-held Victorian belief, warm climates were connected to over-active sexuality of "native" women. Hammond and Jablow 1970, pp. 148-156. See also Collingham 2001, Vaughan 1991.

129 *FCSMR*, October 1906, pp. 447-449; Thompson 1995, pp. 162-163.

130 *The Livingstonia News*, April 1910, pp. 28-29. In 1935, she published a book, *Teaching Healthcraft to African Women*, on health and hygiene. Fraser 1935.

and beer-drinking and beer-brewing. Beer-brewing was usually women's work, and missionaries argued that it resulted in the neglect of children.[131]

The housing of an African Christian family was also an important health issue for the missionaries. In 1904, the joint Missionary Conference of the Protectorate recommended that the administration should discourage the construction of single-roomed huts and common dormitories and that *"in new settlements natives should be advised to build their houses so far apart that each family might be a separate unit."* The division of villages into separate nuclear family units was regarded as advisable for reasons of physical as well as moral hygiene. For Agnes Fraser, bringing children under the same roof as their parents would help to keep the children away from "foul dances", beer-drinking and other evils. Common, unsupervised dormitories for young boys and girls were regarded as being dangerous to moral health, in the villages as well as at the Institution. The Comaroffs have pointed out the connections between clothing, housing, morality and health in early nineteenth-century missionary schemes in Southern Africa, and the Livingstonia blueprints for a healthy society can be seen in similar terms. Social disorder was associated with disease, and "proper" clothing and housing reordered space so that individuals were separated from their environment and the nuclear family was "segregated from its social context".[132]

Leading first-generation African churchmen in Livingstonia, to some extent, seemed to agree with the missionaries over the duties of women, and the importance of women to the creation of a healthy family. In 1908, the Native Christian Conference in its recommendations (which were circulated among all the Kirk Sessions of Livingstonia) stated:

> A woman is not a man's slave, but a fellow-helper… The husband, wife, and children should have a family worship in their house… Parents must keep their children at home, and take up responsibility of their education… Native Christian women should undertake Christian work, especially in taking care of their husbands, children, and houses. [133]

It should be borne in mind that the formal rules set out by the Presbytery and the practical day-to-day arrangements of Christian families did not always coincide. In practice it could be expected, as the Comaroffs have argued in the case of the Tswana, that some would emulate European ways, there would be selective adoption of the rules by others, and that some would reject European influences completely.[134]

Furthermore, some influential African Christian leaders took an active part in the Livingstonia programme of family reform and also influenced missionaries in their policies regarding marriage, for example. At the Institution, following the advice of Yuriah Chirwa, Laws insisted in 1911 that

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131 *The Livingstonia News*, October 1912, pp. 70-71; Fraser 1934, p. 200.

132 *FCSMR*, June 1905, pp. 265-266; Fraser A. 1914, p. 457; Comaroff and Comaroff 1992, pp. 279-280.

133 Livingstonia Presbytery Minutes, 30 January 1908. MNA 47/LIM/3/21.

134 Comaroff and Comaroff 1992, p. 273.

pupils should not be married before they had completed their course, and that teachers should not marry until their training had been completed. The creation of a healthy Christian nuclear family was seen as the foundation of a healthy Christian community and society. Laws' programme, to which at least some of the male converts subscribed, can be understood as a variation of nineteenth-century social paternalism, in which the regeneration of the society was based on a duplication of the benevolent hierarchy of a middle-class family. Senior African Christian men could broadly agree with the paternal emphasis of the programme.[135]

Towards a self-controlling society – African Christians and holistic health

From the 1890s, Christianity became a popular movement in the Livingstonia mission sphere, with an explosive growth in both the numbers of converts and the mission schools.[136] The supervision of the moral condition of the new converts increasingly became the responsibility of the first generation African Christians as teachers, evangelists and church elders. In 1897 the mission reported of the latest 534 baptised adults:

> All are, to the best of our knowledge, total abstainers. No one…is fettered by the bonds of polygamy. And, during a period of probation (a year or more) each life will be subjected to the strictest scrutiny on the part of elders, deacons and other native Christians, who have ways and means, which lie beyond our reach, of finding out all about the village life of the candidates.[137]

The African evangelists and teachers trained at the Institution were essential to the Christian expansion. Laws regarded the Africans as great imitators, not thinkers: they were to be *"imitators of Christ's life, not representatives of intellectual doctrine."* He considered that the trained African converts, "raised out of mud", would demonstrate the process of Christian regeneration most effectively through their example:

> He wears cloth, and washes it. He does not drink beer, and has only one wife, yet his life is not miserable. He can read, and knows many things the other villagers do not… And his presence is a daily rebuke to drunkenness, obscene dancing, and all disorder… And soon his standard of righteousness is that to which the village will appeal. He speaks, too, of coming judgement, and heaven and hell.[138]

Cleanliness, both physical and moral, distinguished the Christians from the "mud" from which they had been raised by missionary education, and now they were to raise up others in their own village communities. In Laws' scheme,

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135 Laws to Innes 24 July 1911. MNA 47/LIM/1/1/13, 430; Comaroff and Comaroff 1992, p. 271.

136 McCracken 2000, pp. 147-169.

137 Quoted in *The Christian*, 24 November 1898, p. 14. NLS, MS. 7908, 168. Elders are elected, unpaid lay members of the Presbyterian Kirk Session, which is chaired by the minister and which acts as a local church court. Macdonald 2000, pp. 10-11.

138 *The Aurora*, October 1898, pp. 33-34.

the missionaries were to become as Christ-like as possible, and their African pupils would, in turn, imitate Christ following the missionary example. It was a process of gradual perfectionism, to which holistic health was central. During the Sabbatical Services at the Institution in 1907, a theme for Saturday's discussions was, "Cleanliness of Person, Clothes, House, and Utensils-Sanitation." Those wanting to ask questions or to seek help in their everyday Christian lives were invited to see Laws in the Dispensary Consulting Room, a space allocated for both spiritual and physical healing and cleansing.[139]

The creation of a self-governing, self-supporting and self-extending African Church, which was the long-term objective of the mission,[140] demanded the creation of an African Christian community that would be able to take care of its own moral and physical health. To ensure this, the missionaries held that it was necessary to emphasise the necessity of discipline, self-control and the feelings of sin, guilt, shame and fear. Frequently these feelings were linked to sickness, health and cleanness.

Beer-drinking remained one practice that was vehemently condemned. In uNgoni the demand for total abstinence was introduced in 1896 – a resolution of local Christians themselves. While the missionaries were beginning to recognise the value of weak beer as part of the local diet, some Christian communities discussed whether a sweet, weak beer should be renounced alongside the stronger varieties.[141] In 1911, the Livingstonia Presbytery formally adopted a policy of "abstinence from intoxicants as a beverage" as a rule for all congregations. With regard to lighter drinks, notably "mtibi" or "chidongwa", the Presbytery left the decision to individual Kirk Sessions. Total abstinence carried the day in most congregations.[142]

Attitudes towards dancing divided both the missionaries and the African Christians. At a missionary conference in Blantyre in 1902, Charles Domingo, a leading theological student at the Institution, eloquently defended some aspects of dancing against missionary intolerance. In Loudon, Charles Chinula, a

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139 Sacramental Services, Livingstonia, October 9-14, 1907. NLS, Acc. 7548 D 71, Letters to the Sub-Committee 1907. However, it should be noted that not all missionaries shared Laws' dogmatic views on evangelist education. Donald Fraser criticised the training of evangelists at the Institution, claiming it suppressed the preaching talents of young Ngoni converts. Moreover, Laws' views on early evangelist education have to be balanced against his ambitious long-term educational plans for the Institution, which he envisioned as being the future University of Central Africa. The Institution set remarkably high educational standards during the headmastership of James Henderson. Laws and Henderson were clearly more ambitious in their educational schemes than their followers. McCracken 2000, pp. 183-187.

140 *The Aurora*, December 1897, p. 41.

141 Stuart, quoted in *FCSMR*, July 1897, pp. 168-169; *The Livingstonia News*, December 1910, p. 92.

142 Livingstonia Presbytery Minutes 19 October 1911. MNA/47/LIM/3/21; Livingstone 1921, p. 340. In the Livingstonia churches the communal wine was, and remains, fruit juice, while at Blantyre, wine was used from the early days of the mission. I am grateful to Dr A.C. Ross for this information. In Livingstonia Presbytery, beer drinking by a church member was a disciplinary offence, but in Blantyre, which followed the lines of the Established Church in Scotland, it was not. McIntosh 1993, pp. 166-167.

teacher and later a reverend, organised dances for mission pupils in secret.[143] Some converts, however, took a more puritanical attitude towards dancing than some of the younger missionaries. In 1904, Chisholm discussed the issue with his "Christian boys" during his tour near Mwenzo, after they had witnessed a "Chikweta" dance that he and the Christians held obscene:

> I suggested that they should encourage the people to dance the harmless dances where the songs and actions are not impure, but some of them thought all dances harmful unless when taken part in by one sex only. So I showed them how to point out the sin and danger and heinousness in the sight of God of such dances when conversing with the headmen in the villages, and told the teachers, whenever they heard the drums beating for evil dances, to gather the children together and have a "sing-song" or games with them in a distant part of the village. [144]

On occasion, the missionaries joined forces with local chiefs and headmen in attacking new dances, which were held to be immoral by both groups. In 1911, Laws appealed to the colonial magistrate in Chintheche Boma, reporting that the chief of Mlowe had requested that Laws come or send some other European to stop the people from dancing the new and "obscene" *daroba* dance. The people were dancing the *daroba* despite the fact that it was opposed by the chief and was contrary to "traditional" morality, argued Laws, who stressed that he was not criticising dancing in general, but warning against a specific new dance condemned by traditional authorities. Furthermore, Laws assured that, if left unchecked, this dance would result in much litigation and court cases that would trouble the colonial magistrate.[145] The prevailing colonial policy was that the dances should be stopped only if the people of the village demanded it, and in 1922, Jack Martin believed that the people of Tongaland were generally reluctant to report "evil dances".[146]

From the 1890s onwards, African teachers and evangelists pioneered missionary expansion, for example in Kasungu, where they had been working for three years before a missionary was sent to the district. Their work was seen to be both challenging and dangerous: "*...in the midst of heathen surroundings, where the moral atmosphere is very largely an abnormal one of uncleanliness in thought, word and deed…*"[147] There was a constant danger of "relapse" among lonely teachers who were beyond the control of a Christian community or a missionary. In this way, a "heathen" village community was an environment as hazardous for African converts as tropical Africa was for European missionaries. If Africa itself was seen as a trial of the missionary character, body

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143 McCracken 2000, p. 239; Thompson 1995, p.152.

144 Chisholm to Daly 25 Jan.–10 March 1904. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee 1904, pp. 55-6.

145 Laws to Resident Magistrate, Chintheche, 16 November 1911. MNA 47/LIM/1/1/13, 638.

146 Martin 22 March 1922. Sinclair 2002, p. 51. According to Mamie Martin, drumming and other loud noises in the villages after 9 PM were made "illegal", but even in Bandawe, where missionary influence was strong, such orders could not be effectively enforced. Martin 3 January 1923. Sinclair 2002, p. 113.

147 Prentice to Smith 4 December 1900. NLS, Acc. 7548 D 69, Letters to the Livingstonia Sub-Committee 1898-1900, 102; *The Livingstonia News,* August 1910, pp. 66-67.

and mind, an unsupervised village was similarly a test of a teacher-evangelist's moral character, nervous- and will-power.

Another danger for pioneer teachers, however, was seen to result from their own fanaticism. Over-enthusiastic attacks against perceived immoral customs could result in serious conflict with the villagers. In 1907, Elmslie mentioned a case of teachers unsuccessfully trying to get the colonial police to stop the dancing through force:

> So unremittingly hard can teachers be on polygamy, beer and dancing that these form the main feature of their preaching; and so incensed were the chiefs and the people that when the commissioner met the Marambo chiefs, they asked him if it was permissible to dance in their villages. He of course said no one would stop them, and so there has been a great resuscitation of heathen customs. The antidote to this is to pour into them the Word of God, in school, class and meeting; preaching Christ, and leaving their practices alone.[148]

The style of education at the Institution sometimes contributed to a zealous Christianity among the students that often seemed, in practice, to simply represent the abolition of beer, polygamy and dancing. Because of this, in some villages teachers were not welcomed, and in others they were driven away by force.[149] The teachers' behaviour may have been, in some cases, interpreted as an assault on the local culture of public health. Beer was offered as a sacrifice to spirits, and some dances such as spirit possession therapies had explicit therapeutic functions. The British authorities did not generally share missionary concerns about drinking, dancing and polygamy or necessarily classify them as unhealthy practices; the authorities occasionally questioned missionaries' use of coercion in their opposition to these activities.[150]

There is evidence that ideas about moral diseases, the connection between sin and sickness, and Christianity as a cure and prophylaxis, not only metaphorically but also literally, were to some extent taken up by the African Christians in their preaching. In 1900, Prentice quoted with approval the evangelist, elder and medical assistant of Bandawe, Stefano Potifar Kaunda, who had addressed those waiting for smallpox vaccination:

> "You have heard of this medicine. You know it is good. You are fleeing from a deadly disease; and you know that those who get this medicine escape. But listen while I tell you of another disease – the disease of sin in the heart. A man who gets vaccinated escapes smallpox; but there are many other diseases, any one of which may kill him. Vaccination is not a safeguard against all diseases. But we can tell you of a safeguard against everything that would destroy the soul. The man that has the Lord Jesus in his heart has life everlasting." And so he went on addressing this crowd of orderly and eager listeners. [151]

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148 *FCSMR*, April 1907, p. 169.

149 *FCSMR*, March 1903, p. 121; March 1904, p. 116.

150 Laws to Candy 2 May 1903. MNA 47/LIM/1/1/5, 374.

151 Prentice to Barbour 18 September 1900. NLS, Acc. 7548 D 69. Letters to the Livingstonia Sub-Committee, 1898-1900, 99. An edited version of this letter was published in *FCSMR*, January 1901, pp. 17-19.

Prentice believed that Kaunda had made a timely appeal to people threatened by the smallpox epidemic. Missionary interpretations of such events must be approached cautiously, yet Prentice's narrative is a somewhat more reliable source than missionary texts in general. Prentice was an eye-witness to the event, he had worked closely with Kaunda in the dispensary for a year and, by this time, having worked in Bandawe for several years, probably had at least a partial understanding of chiTonga. Assuming Prentice's description is reasonably accurate, it is noteworthy that Kaunda locates both the "disease of the sin" and Jesus as medicine (metaphorical vaccination), anatomically in the heart. Furthermore, he stresses the "many other diseases" that the smallpox vaccination could not combat. Assuming that this was interpreted literally by some listeners, becoming a Christian (taking Christ into the heart) could be understood as taking preventive medicine. Furthermore, "many other diseases", could also include "diseases of man" in the local medical theory, i.e. illnesses caused by witchcraft or "bad medicines". As Wiseman Chirwa has pointed out, the Tonga found it difficult to understand the missionary dichotomy between the soul and the body, apparent in missionary visions of life after death. The spiritual and the physical were closely interconnected in Tonga belief and for this reason the Watchtower preaching of Eliot Kamwana was to hold a particular appeal.[152] In this light, the medical missionary combination of the soul and the body, as interpreted and developed by Stefano Kaunda in the vernacular, appears to have been appealing and to some degree effective, because it could be interpreted literally by those awaiting vaccination during a deadly epidemic.

The following extract from an African evangelist R.M.M.'s diary was quoted in the *Record* in 1905:

> ...we met a wicked man who was a polygamist… One of us said to him: "How are you getting on with your terrible sickness?" The man said, "I have never felt any pain in my body all these days" "No, you are very sick indeed, and are at the point of death if you don't run quickly to the Physician." "What about you, friends?" asked the man, "We were once in the same position as you are, but as soon as we heard there is great Physician, who is willing to save those who are terribly ill, we ran to Him and asked Him to heal us. To-day we are getting better, and are not so bad as you are"…The man stood up with something of a glad face. He went home and dismissed all his wives save the first one.[153]

The writer believed that the polygamist's reform was the result of a prayer session held on a hill the previous day. For these evangelists, prayer was a force that could both heal and save an ill and sinful polygamist. The connections between sin and sickness and prayer and healing were stressed in medical

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152 During 1900-1901, smallpox was an acute concern in the Malawi region. In 1901, Boxer reported from Kasungu that "smallpox had cleared whole districts". Boxer to Overtoun 5 November 1901. NLS, Acc. 7548 D 70. Henderson 9 November 1901. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee, 1901-1904, pp. 32-33; Chirwa 1983/1984.

153 R.M.M.: "Extract from a Native Evangelist's Diary" 28 September 1904, NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1905, p. 23, quoted in *FCSMR*, April 1905, p. 172.

missionary preaching and practice. The first generation of African teacher-evangelists, medical assistants, preachers and later ministers took up some of these themes and developed them in turn. However, with only occasional and probably inaccurate missionary translations of their early preaching, it is difficult to assess this process in detail here.

That the missionary programme of holistic health and Christian regeneration had long-lasting influences among the African Christian community seems clear, however. McCracken notes how E.B. Manda, the radical pastor and teacher, subscribed fully to Laws' ideas in a speech to congratulate Laws in 1925: before the arrival of Laws, *"the country… was naked in spirit, intellect and body"* but now, *"men who once were brutes are now changed into sensible human beings."*[154]

In some issues of moral health, there was room for compromise. In July 1922, the issue of beer drinking was debated intensively in the Mombera Native Association. In this instance, however, health arguments were not brought to the fore, rather the Association emphasised the high number of legal cases connected to intoxication that had been brought before both the Native Courts and the Boma. Eventually, *"After a long and hot discussion all the members agreed that the people should drink less beer."* [155] In a compromise between abstainers and beer-drinkers, the Association advocated the promotion of moderation rather than total abstinence. The colonial authorities concurred, not seeing much harm in beer-brewing and consuming on a small scale. They placed the responsibility for checking large-scale brewing and drinking firmly on the Principal Headmen.[156] In 1926, the Association discussed the matter again and the dangers of beer were considered to be twofold. Firstly, beer could be used as a medium for "bad medicine" or poisoning, especially when beer was served in large quantities in social gatherings. Secondly, beer drunk "without self-restraint" would "cause disease in the stomach of a drunkard". All chiefs and "drunkards" were therefore advised to drink with care.[157]

However, some Livingstonia graduates agreed fully with Laws' emphasis on the importance of will power, nerves and moral health to individual and collective well-being, and advocated total abstinence on health grounds. In 1931, Fred Nyirenda, a Livingstonia-trained hospital assistant at Karonga, published an article on the dangers of beer-drinking in the mission periodical *Vyaro na Vyaro*. Nyirenda first described the anatomy and physiology of the nervous system. He went on to advise training, exercise, nourishment and rest for the brain. Nyirenda warned of the damage caused to the nervous system by alcohol, with the cumulative destruction of the senses, self-control and morality. Nyirenda argued that large quantities of alcohol were lethal, and that continued drinking caused "terrible injury to the brain", gradually destroying sensation, will-power and self-control. He claimed that strong drink caused forty per cent of all cases of insanity, ninety per cent of all cases of violence and "much of the

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[154] Quoted in McCracken 2000, p. 193.
[155] Minutes of MoNA 28-31 July 1922. MNA S1/210/20.
[156] Chief Secretary to Secretary, MoNA, 19 December 1922. MNA S1/210/20.
[157] Minutes of the MoNA 26-27 May 1926. MNA S1/1365/24.

poverty in our land", and asserted that for every person who was insane as a result of drink, there were twenty more with brain injuries, moral impairment and a limited capacity for work.[158] There is evidence that some mission-educated medical assistants also shared missionary concerns about polygamy, sexual morality and venereal disease.[159]

158 Nyirenda, "The Danger of Beer Drinking", *Vyaro na Vyaro,* November 1931, p. 6.

159 Megan Vaughan has cited an African health assistant in Nyasaland in the 1940s, discussing the problem of venereal diseases in the Protectorate. For this assistant, the problems were "illegal marriages, social dances; beer and polygamy". Polygamy contributed to the spread of venereal disease because "some of the wives are unfaithful, infect the husband, who infects the other wives." Quoted in Vaughan 1994b, p. 180.

8 MISSIONARIES, CHRISTIANS AND AFRICAN HEALERS, 1875–1930

8.1 Missionary doctors and African healers

The Livingstonia doctors' preconceptions about African healing were influenced by the wider European explorer and missionary writings. On the one hand, there was little information available about Central African societies, the published journals of David Livingstone being almost the sole source of information in English. On the other hand, a distinct medical missionary tradition existed which was based upon experiences in Asia. From the 1840s, Scottish medical mission protagonists had published writings that promoted the use of medicine as a handmaid of the gospel. These authors stressed that by demonstrating the superiority of Western medicine to the medical traditions of other religions the medical missionary could attack indigenous "priest-physicians" and so prepare the ground for religious conversion. Their publications were generally very dismissive of non-western medical practices. Indigenous medicine was understood to be based on superstition, ignorance, false religious beliefs and a lack of scientific knowledge. At best, it might provide knowledge about new drugs, which could be added to the Western Pharmacopeia.[1] Labelling controversial medical ideas and practices, such as hydropathy, as products of "ignorance" and "darkness" was also typical of the rhetoric of Victorian medical orthodoxy. Indigenous practitioners in the Empire along with domestic hydropaths, homeopaths and "kinesipaths" were all similarly labelled "quacks" in mainstream medical discourse which was

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1 *Lectures on Medical Missions* 1859, pp. 24-26, 38-39, 93-96; Lowe 1886, p. 41. Cinchona bark, the plant from which quinine is derived, had been imported to Europe from the New World in the early seventeenth century by the Jesuit missionaries. For the general history of cinchona, quinine and malaria, see Honigsbaum 2001; Rocco 2003.

informed and reinforced by missionary and colonial discourses of the imperial "others".[2]

It was typical of nineteenth-century Western medicine to absorb new medicines from indigenous healing systems into its repertoire, but never with any serious intention to accommodate these systems in their own right. Western doctors rarely tried to understand local healing systems as a whole. As David Arnold has observed in the case of colonial medicine in India, "Appropriation, subordination, and denigration were the processes by which Western medicine marked its conquest over indigenous medicine." It was taken for granted that the thought-systems underpinning indigenous medicine were inherently flawed.[3] When these patterns of thought were connected to indigenous religion (as was often the case), Christian medical missionaries would usually ridicule and reject local medical culture. Nineteenth-century Western doctors and missionaries shared the rhetoric of derision in many of their descriptions of non-Western medical cultures.[4]

In this light, David Livingstone's attitude towards African medicine and healers was remarkably sympathetic, as many scholars have noted. His famous discussion with an African "rain-doctor" can almost be regarded as collegial. Although often critical of local practices, Livingstone regarded some of local African treatments as effective, and was willing to try them himself when suffering from bouts of fever.[5] Livingstone's tolerance of, and interest in African medical practices has been explained in various ways: according to Michael Gelfand, it was due to Livingstone's medical training and scientific approach; for Angus Calder, it was because of Livingstone's Highlander background and his knowledge of the "wise women" of the Highlands and the Islands.[6]

It seems plausible that the respect Livingstone had for inherited knowledge owed something to the high value he placed on Highlander family traditions. Nevertheless, whatever his reasons, Livingstone personally experimented with African treatments, especially those for fever. He also collected African herbal medicines, and urged European doctors to study African medical practices and practitioners. Livingstone argued that those African doctors who had inherited their position usually possessed valuable empirical knowledge. He considered such healers to be regular practitioners, and remained on good terms with them. Conversely, he also believed that *"if a man cannot say that the medical art is in his family, he may be considered a quack."*[7]

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2 Bradley 2002, p. 26; Haynes 2001, pp. 23-24. As Haynes has noted, for the metropolitan medical profession, the missionaries' negative portrayal of Chinese medicine and culture as backward was useful in the construction of "British medicine as the symbol of the West...modern and progressive." However, secular doctors were also concerned about the threat posed by charitable medical missionaries to commercial practitioners.

3 Arnold 1993, pp. 58-60 and passim.; Cunningham and Andrews (eds.) 1997, pp. 1-15. See also Arnold (ed.) 1988.

4 Cf. Mudimbe 1988, pp. 47-54.

5 Livingstone 1857, pp. 20-22, 114, 164; Cook 1994, p. 38; Gelfand 1957, pp. 5,11; Forster 1989, p. 4.

6 Gelfand 1957, p. 5; Calder 1996, p. 98.

7 Livingstone 1857, pp. 114-115; Gelfand 1957, pp. 5, 11.

This distinction between honest practitioners with inherited knowledge and "quacks" would last in Scottish missionary commentary well into the twentieth century.

However, Livingstone was not unique in his relatively positive attitudes towards African medicine in mid-nineteenth-century Southern Africa. Norman Etherington has shown how Henry Callaway, a missionary and a medical doctor in Natal, was genuinely interested in, and sympathetic towards indigenous medical practices.[8] Furthermore, following David Gordon, it can be argued that during the early period of colonial settlement in South Africa, there was "an important exchange of medical ideas and identities, leading to a dynamic therapeutic pluralism." In these circumstances, the distinctions between "European" and "African" medicine became blurred. A prime example of this pluralism could be seen in the practice of Dr Fitzgerald, who began to incorporate African medical elements into his repertoire. Gordon argues that "therapeutic pluralism", which began to wane towards the end of the nineteenth century, was possible in the conditions of the "weak colonial state and the nature of pre-capitalist settler encroachment."[9] For Livingstone, Callaway and perhaps also for Fitzgerald, it seems that it was the acute recognition of their own limitations as doctors in Africa that encouraged their interest in African medicine. They had studied medicine in more open medical establishments than the later Victorian physicians, and they belonged to a generation of doctors who graduated before medical registration legislation formally and rigidly defined the spheres of orthodox and unorthodox medicine in Britain.[10]

In Robert Laws' first medical report of Livingstonia Mission for 1876–77, he dismissed outright any suggestion that the local healing practices had any real value. In contrast to African healers' methods, Laws highlighted the missionary surgeon's use of chloroform as a marker between African and Western medicine:

> Chloroform by itself has in the native mind, drawn a distinct line between the medicine and the practice of the English doctor, and that of the native dealer in charms and practices too hideous to mention.[11]

The local healer for Laws was not a doctor, but a "dealer in charms and practices", which suggested that he was viewed as a charlatan and a medical quack. The short description of his activity as "too hideous to mention" had a sensational streak, while providing a pretext for missionaries to ignore local healers. There was no trace of Livingstone's cordial collegiality in the report. In the published account of work in Livingstonia during the period 1885–90, it was bluntly stated that African people *"have no means of healing"*.[12]

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8 Etherington 1987, pp. 77-91.
9 Gordon 2001, pp. 165-184.
10 Comaroff and Comaroff 1997, p. 328; Etherington 1987, p. 80; Saks 1999, p. 382.
11 Medical Report for 1876-1877. NLS, MS. 7908.
12 *Livingstonia mission...a six years' history and appeal.* 1881.

Though Laws' medical report condemned indigenous medical practice in passing, and he dismissed African medicine in his public writings, he did not abandon Livingstone's attitudes completely in this respect. It is also noteworthy that at this stage Laws does not write of "witch doctors", a term that seems to have become a commonplace in Western narratives of African healers during the 1880s. In chapter 6 it has been noted how one of the headmen Laws left in charge of jurisdiction at the Cape Maclear was Kabanda, "an old witch doctor" according to W.P. Livingstone, and that the relations between the two must have been cordial.[13] A manuscript issue of *The Aurora* magazine from the 1880s contained a handwritten list of "Suggestions for Papers" by Laws. Among a plethora of other topics, Laws suggested papers on *"Medical Work – Native Epidemics, – native treatment of diseases. Botany – Scientific names of trees, shrubs or flowers, especially those of a useful or medical nature with native names for them."*[14] This suggests that Laws was not only genuinely interested in local medicine, above all in the classification of local medical plants (botany had been his strongest subject while at the university), but also in the study of treatment. There is, however, no evidence available that Laws actually undertook such a survey. However, some medical missionaries did practise amateur medical ethnography to some degree.[15]

After Walter Elmslie's arrival in uNgoni in early 1885, the paramount chief M'mbelwa and several other influential figures made requests for medicine, but to Elmslie's disappointment, they seemed to regard most of his medicines *"as charms just as their own."* Therefore, Elmslie pinned his hopes for demonstrating the value of Western medicine upon surgical practice, where in his view, there was *"no room for such ideas"*.[16] In early 1886, Elmslie wrote an article for the *Monthly Record*, stressing the importance of his medical challenge to the local practitioners, whose power was based on their connection to the spirit world:

> They [the Ngoni] are, from frequent sickness, death and other events, constantly in the hands of the native doctors, who are trusted to the utmost as the only channel of communication with spirits. Consequently, the doctors have the people completely in their power, and except in one instance (our nearest neighbour, and a regular attender at our services) these doctors are decidedly against us, because their craft is in danger.[17]

Elmslie's account contained its own ethnic or racial hierarchy of "superstitions". He regarded the beliefs and practices of "Zulu-Kafirs", the original Ngoni, to be

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13 Livingstone 1921, p. 188. The origins of the term "witch doctor" were discussed in the H-Africa discussion network during 2005. According to Christopher Lowe, the term first appeared in Southern Africa in the early 1850s and was universally adopted after about 1880. Christopher Lowe. <clowe@igc.org>, "Origins of the term 'witch doctor'", 25 August 2005, <http://www.h-net.org/~africa/>, (25 September 2005).

14 Aurora MS issues. NLS, Acc. 7548 D 75.

15 In 1897, George Prentice wrote in the *Monthly Record* that, *"a native doctor is collecting medicine roots for me, and I hope to take a large collection home" FCSMR*, September 1897, pp. 221-222.

16 Elmslie to Smith 29 May 1885, quoted in *FCSMR*, October 1885, pp. 299-300.

17 *FCSMR*, May 1886, p. 138.

superior to those of the conquered peoples of the Zambezi region, whose "thought forms" were to him *"more barbarous and deep-rooted"*.[18]

Elmslie drew a vivid picture of the clash between the local healers and himself. To him, "native doctors" had remarkable power over the people, and this power was based on deceit. However, Elmslie actually admitted that African doctors were skilled in their assessment of the severity of an illness: for him, the local healers were playing on the fears and supernatural beliefs of their patients. Elmslie noted that the doctors often charged their patients several times, and finally cashed in on the sacrifice of an ox to the spirits after death. In contrast, he told his readers, the missionary doctor helped his patients without charge and explained the "truth" of the situation. Elmslie believed that the authority and influence of local healers could be most efficiently undermined through such demonstrations of Christian charity and "scientific" treatment.[19]

At this time, Elmslie's understanding of the vernacular language could not have been particularly advanced. As noted above, until his death in June 1886, the Xhosa evangelist William Koyi translated and mediated for Elmslie in his dealings with his patients. Koyi was probably Elmslie's main source of information about Ngoni medicine and he was known to be on good terms with Kalengo Tembo, the nearest local healer.[20] In his early article, Elmslie did not recognise different medical specialists, or any order of precedence among local healers, although he believed that the missionary doctor, a new type of practitioner, was usually only consulted when all other methods had failed. Without any clear distinction between diviners and other practitioners, Elmslie presented the general "native doctor" as first treating the case, and then, if a patient's condition worsened, consulting spirits, and after death, appeasing spirits through sacrifice. According to Read, however, diviners in Ngoni society did not always personally treat patients suffering from illness caused by witchcraft or "natural" disease, but could refer them to other practitioners.[21]

Elmslie appears to contradict himself in his interpretation of healers' attitudes towards the mission in uNgoni. If the healers had the people "completely in their power" and were "decidedly against the mission", it is unlikely that the missionaries would have been welcomed at all. Furthermore, Elmslie discussed their nearest neighbour, a healer who clearly supported the mission and regularly attended the missionaries' services though he showed no signs of conversion. Paying more attention to such a figure in a missionary publication would not fit neatly into the narrative of confrontation typical of the missionary discourse: the medical missionary, armed with the light of the Gospel and medical science, challenges and overcomes the "native doctor", a charlatan abusing people's superstitious beliefs.[22] It seems that some healers actively opposed the missionaries, while others at least were prepared to

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18 Ibid.

19 Ibid.

20 Elmslie to Laws 6 June 1887. NLS, MS. 7890, 127; Elmslie 1901, p. 223; Thompson 2000.

21 Read 1970, pp. 39-40, 71.

22 This view is well presented in Elmslie 1901, p. 153.

tolerate the new practitioners. Elmslie's challenge to the local medical orthodoxy was checked by the limited potential of his medical and surgical resources as well as their unfamiliarity to his African patients.

Vail has noted that in the late nineteenth century, there was a marked change from traditional military values towards market values within Ngoni society. Increasing numbers of Ngoni were trading in ivory and slaves. Medicine was one area of business that was, in principle, open to all members of society;[23] and (as Elmslie observed) respected doctors were paid well. For these established practitioners there was little reason to be afraid of the new white doctor, who offered largely minor specialised cures such as dentistry. Elmslie's charitable practice may have aroused further suspicion of his motivations or of the value of his cures. As Patrick Manson (an Aberdeen graduate of an older generation and a critic of charitable missionary medicine in China) observed during his time as port surgeon and mission physician in Amoy in the 1870s: *"Most people recover from most sicknesses whether by European or Chinese physicians. The Chinaman can point to numerous so called cures by his own medicines, and declines to abandon the old, so long as there is what he considers known good to it, for the new with unknown and indefinite in it."*[24] Manson's analysis has relevance to the situation in Central Africa. In time, Elmslie became a strong advocate of medical fees. Like Manson, he believed that even though Western medicine was superior to indigenous medicine, so long as clear material value was only assigned to indigenous medicine, there would be no grounds for comparison between the two.[25]

It is clear that both Laws and Elmslie generally considered the African healers to be essentially just clever quacks looking for profit. This attitude reflected the metropolitan concerns of the medical profession in Britain.[26] A quack, it can be argued, would suspect that his or her medicines did not work, and would be cheating people knowingly. So, these intelligent and observant individuals would not really share their fellow men's beliefs, but would abuse them for personal gain. Premesh Lalu has described how, in South African medical writings from the 1890s, the "native doctors" were caricatured as greedy quacks who were clearly distinguished from the white professional doctors. However, although local healing practices were widely denigrated, there was a consensus that medical anthropological appropriation of local knowledge could enrich Western medical expertise. In the classification and use of African medicinal plants, African doctors were consulted, but when local treatments were incorporated in Western practice, the "discovery" was attributed to white doctors. Significantly, in the treatment of snakebites, when Western doctors depended overtly on local knowledge, labels such as "quackery", "superstition", or "witch doctor" were never applied to indigenous remedies.[27]

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23 Vail 1983, pp. 243-252.
24 Manson, quoted in Haynes 2001, p. 25.
25 See Chapter 6; Haynes 2001, p. 25.
26 See, for example, Haynes 2001, pp. 23-25; Smith 1979, pp. 333-342.
27 Lalu 1998, pp. 138-143.

There is evidence that by the 1890s at least, the Livingstonia doctors held private, more positive views of African healers that were never expressed in missionary magazines. James Johnston (a Scottish missionary doctor from Jamaica who travelled in Central Africa and visited Livingstonia in 1892) commented favourably upon the efficiency of some herbal cures. Significantly, Johnston quoted a "Dr E. of Livingstonia mission", undoubtedly Walter Elmslie, who had told him of a seemingly hopeless ulcer case which was, after being treated for weeks by the missionary doctor with no improvement, almost miraculously cured by a local healer in a very short time.[28]

Another doctor who had respect for African healers was Cross, who was referred to in Sir Harry Johnston's book, *British Central Africa.* Sir Harry, the first Commissioner of the British Central Africa Protectorate, published his work in 1897. An amateur ethnographer, Johnston represented local medical practitioners in a relatively sympathetic light, arguing that although they relied heavily on mysticism, the herbalists had "considerable knowledge of drugs" and could provide "remarkable cures by honest therapeutics" even in cases that were viewed as incurable from a Western point of view. He classified African medical practitioners into two groups: those who relied only on magic and those "genuine doctors" whose "honest" therapeutic powers derived from their knowledge of various herbal cures. He encouraged the scientific study of the latter's medicines, pointing out that one Central African drug, Strophanthus, had already been introduced to British Pharmacopoeia.[29]

Cross, who had resigned from Livingstonia in 1897 and joined the Protectorate administration as a medical officer, confirmed Sir Harry's positive view of some African healing practices, drawing on his personal experience among the Ngonde at the north end of the lake. Again, herbal cures were singled out but Cross also praised the dry-cupping skills of Ngonde healers, arguing that *"We have a lot to learn from Wankonde doctors."*[30] Such a public statement was at the time only possible in exceptional circumstances. Cross had just resigned, and he was perhaps not even aware that Sir Harry was going to quote him in this way.

In his 1899 book, *Among the Wild Ngoni,* which became something of a missionary "best-seller", Elmslie presented a more extensive account of indigenous healing practices and practitioners. As Peter Forster has pointed out, Elmslie attacked Ngoni medical practices with particular force.[31] He asserted that the Ngoni "witch-doctor", *itshanusi,* was "either self-deceived or a base impostor", though a "shrewd individual" who was frequently used by "wicked" chiefs. The *itshanusi* claimed to have specialist knowledge of the affairs of individuals as well as communities, and an ability to communicate with the ancestral spirits. In this account, Elmslie's "witch doctors" were those

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[28] Johnston 1969, pp. 334-336. See also King and King 1991, p. 24. Johnston had met Elmslie in 1892 at the Bandawe station. Elmslie to Laws 22 October 1892. NLS, MS. 7896, 146.

[29] Johnston 1897, pp. 442-443.

[30] Cross, quoted in Johnston 1897, footnotes for pp. 442-443.

[31] Forster 1986, p. 105.

with non-inherited powers of divination. He distinguished them clearly from other doctors, *"medicine men who have a knowledge of herbs"*, whom he mentioned only in passing, recognising that they had inherited their knowledge. This inherited knowledge was passed down through the generations of a family.[32]

The "witch-doctor", in turn, was chosen by the ancestral spirits through possession. After a period of withdrawal from the society, sometimes involving "peculiar" sickness, dreams and fits, the potential "witch-doctor" was tested and if possession was found to be genuine, he would be trained by an older "witch-doctor". The candidate would be accepted as a "witch-doctor" only after finding a potent medicine, and publicly proving *"his ability to discover things secreted by those assembled to test his powers. There is doubtless a measure of both self-deception and imposture in this matter."*[33] Elmslie described a developed course of training, involving both specialist and public testing of the candidate.

For Elmslie, *itshanusi* ("witch doctor") and a spirit-possessed diviner were one and the same type of healer. The other healers, whose knowledge had been passed down through their families, belonged to the second category. In this scheme, anyone who dealt with the spirit world was deemed to be a "witch doctor". Elmslie's story unequivocally presented the triumph of mission medicine over the African doctors: *"One of the greatest effects of the medical mission work was that, by it, the empiricism of the native doctors was overthrown, and the common people, ignorant and superstitious, were rescued from the bondage of their shrewd but deceitful impostors."*[34] Here Elmslie did not differentiate between different types of healers, deriding all "native doctors".

Although Elmslie was dismissive of all African practitioners, he reserved his most scathing criticism for the "witch doctor/itshanusi" category, which he explicitly connected to the Ngoni belief system. For missionaries, it was imperative to abolish belief in ancestral spirits and in witchcraft. Inherited knowledge of herbal medicines was a different matter and by remaining tactfully silent about "other doctors", Elmslie arguably allowed them to practise quietly in the footnotes of the heroic medical missionary narrative. Like Livingstone, he seemed to place some value on knowledge passed down through families. Even in his most triumphant missionary accounts, Elmslie indirectly admitted that some African treatments worked, though he stressed their limitations rather than their potential strengths: *"Native doctors fail in diagnosis more than in power to heal."*[35] His attack on the "empiricism" of the African doctors was a general condemnation of all African medicine, in comparison with the "scientific" Western medical knowledge.

Elmslie may have recognised the potency of some African medicines, but he was unambiguous in his condemnation of the thought–systems and ethics that underpinned local medical practices. At a missionary conference in 1900,

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32 Elmslie 1901, pp. 60-66. According to Silas Ncozana: "In the Ngoni language the word hnusa means to 'smell out', to 'detect'. The vyanusi or 'smeller', as the medium be called, believed by the Ngoni to have supernatural powers to detect hidden danger, was a prophet." [underlining original] Ncozana 1985, pp. 152-155.

33 Elmslie 1901, p. 67.

34 Ibid., p. 153.

35 Ibid.

he argued that it was essential for the safety of the African Church, and to the healthy development of the faith of the converts, to provide a Western Christian alternative to "native doctors", whose treatment he described as *"often obscene and at all times ignorant and superstitious."* Admittedly, in 1900, Elmslie did not claim that the local healers, who were classified under the single category of "native doctors", were incapable of healing people. He argued instead that not only was their treatment based on false presuppositions and religious beliefs, but also that it was morally dangerous, dirty and, "obscene".[36] It was these features of indigenous medical practice that were, in the eyes of the missionaries, particular dangers for African converts. By the end of the century, the number of converts in uNgoni and uTonga had increased significantly. For Elmslie, the African Christians put their spiritual life and development at risk if in times of sickness they chose a local healer instead of a missionary doctor. At this time, the missionary doctor was less involved in curing the body than correcting the "error, physical, mental and moral", an emphasis which compensated for frequent disappointments with the efficacy of the treatment.[37] Initially Elmslie had believed that charitable medicine would not prevent missionary doctors being perceived as efficient, scientific healers of African bodies. By 1900, this attitude had been replaced with the strong belief that free treatment was actually detrimental to the reputation of missionary medicine.

Elmslie's vehement opposition to local doctors and to charitable medicine was largely based on his early experiences in uNgoni. After two years' service, he had become increasingly disappointed with the response to his practice, and complained that he rarely received any rewards as gestures of gratitude from his patients. Matters came to a head in 1887 when Elmslie thought that he had successfully treated a female patient who was suffering from constipation and who had previously consulted a local healer without success. The husband of the patient, a half-brother of the paramount chief, argued that, although Elmslie was the superior doctor, the local healer still *"claimed the cure because he claimed the payment."* As Elmslie had been so generous as to treat his wife for nothing, he now asked Elmslie for compensation for his *"professional brother"*. Elmslie was so enraged by this request from a man who *"had over a hundred cattle"*, that he later refused to treat his wife in childbirth. For him, the case illustrated that free treatment undermined the status and authority of the missionary doctor. Without medical fees, he later argued, Africans would come to regard the medical missionaries either as extremely wealthy philanthropists or *"soft ones to be bled"*.[38]

In contrast to Elmslie's picture of the direct confrontation between the medical missionary and the local healers, there is important evidence to suggest that African healers' attitudes towards the missionary doctor could be tolerant,

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36 *Report of the Meetings held at the Livingstonia Institution...*1901, pp. 31-32; Elmslie 1901, pp. 66-67, 72.

37 Elmslie 1901, p. 227. On the conversion among the Ngoni, see McCracken 2000, Ch. 5; Thompson 1995, *passim.*

38 Elmslie to Laws 6 June 1887. NLS, MS. 7890, 127.; *The Livingstonia News*, April 1909, pp. 27-30.

and that they were sometimes positively interested in missionary medicine. According to Yesaya Chibambo, in uNgoni, famous diviners, such as Gwaza Jere and Ntondolo Mvula of Ekwendeni (a famous Senga diviner) had foretold the coming of the strangers from the sea. Chibambo argued that these diviners' prophesies, which advised the people not to fight with the newcomers, later prevented violence towards the Europeans.[39] Such predictions were taken seriously by the Ngoni medical specialists, and if the presence of the white strangers had to be accepted, they also had to find ways of coping with white healers. During the drought of 1886 it was the diviners who ascertained that the missionaries were not to blame. Following Silas Ncozana, it can be argued that by this time, Elmslie was seen as an alternative power medium, who was asked to pray for rain. Although Elmslie agreed, he was careful not to wield his Bible like "a charm", and did not take it to the royal kraal.[40]

By the time he wrote *Among the Wild Ngoni* in 1899, Elmslie's knowledge of Ngoni society and his understanding of vernacular languages had developed over ten years. He had access to a wide range of informants, certainly among the new Christian converts, including the three brothers of the Tembo family. The history of this family provides some important insights into the interaction between African and missionary medicine in uNgoni. The local healer in Njuyu and the missionaries' "nearest neighbour", Kalengo Tembo, sent his sons Chitezi, Mawelera and Makara to learn from the white doctor, first secretly at night, as the boys were afraid of the paramount chief's disapproval. Mawelera and Makara eventually became the first converts in uNgoni. Chitezi, the eldest brother, was a respected warrior and M'mbelwa's favourite, and he became a crucial go-between for the missionaries and the paramount in the 1880s and early 1890s, a role later adopted by his brother Mawelera. Because Chitezi had become a head of a polygamous household by the time his brothers were baptised, he never formally became Christian, although he seems to have lived largely in a Christian fashion. According to Thompson, Kalengo Tembo believed that the drought in the area in 1885–86 was actually the result of the Ngoni failing to heed the missionaries' message.[41]

The Tembos' early alliance with the missionaries was not without its risks. Although during the "rain question" of 1886, the diviners had agreed that the missionaries were not to blame, the issue had divided the opinions among the Ngoni. The Tembos had clearly sided with the missionaries, who feared an attack on the Njuyu station. Elmslie reported that two days before the rain finally fell, a watch had been set up at night with every gun on the station loaded. The Tembos had been on watch with the missionaries, and according to Elmslie, Kalengo *"actually expected that their time was come"*. In a letter to Cross in February 1886, Elmslie reported that Kalengo had said, *"We were nothing till you came – you have made us forget we are slaves, as we are all treated alike by you."*[42] The

39 Chibambo 1942, pp. 52-53; Ncozana 1985, pp. 158-161.
40 Ncozana 1985, pp. 173-177; Thompson 1995, pp. 51-53.
41 Chibambo 1942, p. 63; Ross (ed.) 1996, p. 29; Thompson 1995, p. 14, 51; Thompson 2000.
42 Elmslie to Cross 8 February 1886. Quoted in Ross (ed.) 1996, p. 29.

Tembos seem to have belonged to the freed slave section of Ngoni society.[43] The healing and divining profession of Kalengo enabled him to gain greater status, wealth and social mobility than would have been otherwise possible, but the family's position was not secure. Openly siding with the missionaries was a considerable risk, but one which Kalengo Tembo was willing to take, because alliance with the missionaries offered him access to new knowledge and possibility of improving his family's social standing.

Elmslie had designated Kalengo Tembo's medical practice to the category of the "smeller-out". His healing activities included the use of drumming and singing to exorcise "demons", i.e. to treat spirit possession. When Tembo discovered the hostility of the missionaries towards his practice, he withdrew his "consulting-room" to another village, about seven miles away. Elmslie was not sure whether it was to avoid *"… the light which revealed his darkness, or out of respect to us"*,[44] but believed it was the latter, as at the same time Tembo withdrew his children (who were at the mission school) from participating in his practice as drummers. Furthermore, Tembo encouraged his sons to stay with the missionaries, spoke well of the mission within the neighbourhood and continued to send his wives and children to Elmslie for treatment. Elmslie simply concluded that the case demonstrated how difficult it was for an older African to give up his traditional beliefs for Christianity.

In *Among the Wild Ngoni*, Elmslie recounted a case when Chitezi Tembo fell ill and the cause was identified as *virombo* spirit possession. Kalengo had arranged a dance to exorcise the troubling spirit, and Elmslie claimed Chitezi *"gave a passive obedience to the arrangements"*. Elmslie was approached first to send some blue cloth that the spirit was believed to be searching for. Elmslie refused, and a few hours later Chitezi sent him a note, requesting:

> …my Zulu Bible, as, while he had to submit to his father, he desired to show he did not believe in what was going on. In the evening I went to see him and found his father, painted with red clay, in the midst of his divining instruments, and in a circle around him and his son, who sat reading the Bible, the drummers and dancers performed… Such dances and performances were common enough in the country, but never before where the subject of them sat reading the Word of God. Parental anxiety was no doubt shown, and on the son's part filial obedience. The one was not able to exercise implicit faith in God and Gospel, and hence fell back on that which gave his mind rest; and the other was not strong enough to declare a separation from the superstitions in which he had been brought up.[45]

This exceptional case of spirit possession has previously been analysed by Ncozana. Ncozana does not mention, however, that Kalengo was a healer[46], but

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43 Thompson identifies Kalengo Tembo as Senga. According to Mkandawire (1971) the Tembos were "all Karanga".

44 Elmslie 1901, pp. 223-224. In Elmslie's description, the practice of Kalengo Tembo seems clearly to have included both divining and dealing with spirit possession.

45 Ibid., pp. 225-226.

46 Ncozana 1985, pp. 144, 149, 209-210. Ncozana erroneously dates the incident to 1908. Elmslie's account does not give a date, but the case certainly occurred before the first publication of *Among the Wild Ngoni* in 1899.

states that the father consulted a *nganga*, and was informed that a *virombo* expert was needed to exorcise the spirit possessing Chitezi. However, from Elmslie's account, and his earlier description of Kalengo's practice, it seems that Kalengo himself was in charge of the treatment. He arranged the dance, which may or may not have involved a spirit possession specialist other than himself. He sat in the circle with his son, painted in red clay, with his "divining instruments".[47]

Unlike Elmslie, who asserted that Chitezi did not believe in his father's treatment, but accepted it out of "filial obedience", Ncozana suggests that Chitezi and his father regarded the dance and the Bible as "complementary methods for healing disease". Ncozana points out the importance of the fact that the Bible was accepted in the ritual, arguing this indicates that the Tumbuka were changing their tradition, "accepting a new power… [and] making an effort to indigenize the Bible and the Christian faith."[48] This reading suggests that Chitezi retained respect for and connections to his father and his profession. It can be argued that Kalengo Tembo, who was in charge of the treatment, combined his own and Elmslie's perceived powers to treat his son. It is even possible that possession led to Chitezi subsequently becoming a possession healer himself, as is often the case especially with *vyanusi*-type spirit possession, according to Boston Soko.[49]

Mawelera Tembo (d.1937), became Elmslie's first medical assistant during the 1890s, and was later independently in charge of a mission dispensary. He also became a well-known and influential evangelist and a church elder for over forty years as well as an adviser to Ngoni paramount chiefs and a member of the Mombera Native Association. Assuming that as a child Mawelera participated in his father's practice, he would have been familiar with local healing theories and practices, as well as missionary medicine. What he perhaps accepted, and what he rejected, cannot be reconstructed from the sources consulted here. However, Elmslie mentioned casually that Mawelera's family background reinforced his status as a healer among the people, and this did not seem to trouble the missionary doctor at all.[50]

It can be argued, with reason, that Kalengo Tembo recognised the missionaries, and Elmslie in particular, as alternative and complementary medical and spiritual specialists, who possessed useful new knowledge that his children should learn. William Koyi probably played an important part in this before Elmslie's arrival. Ncozana plausibly suggests that Tembo wanted his sons to "access new untested divine energies."[51] When he learned that the missionaries did not accept his own practice, he withdrew his children from it, at least openly. He accepted the use of the Bible, as a new form of potential medicine, in the spirit possession therapy dance and ritual. He sometimes sent

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47 This would seem to suggest that Kalengo Tembo was a *virombo nchimi*, but it is extremely difficult to determine whether he was called a *virombo nchimi, vimbuza nchimi,* or *vyanusi* medium. All of these specialists can have both healing and divining skills, according to Ncozana.

48 Ncozana 1985, pp. 209-210.

49 Soko 1987, p. 9.

50 *Report on Foreign Missions for 1897*, pp. 95-96; Ncozana 1985, p. 184.

51 Ncozana 1985, p. 184.

his own family members to Elmslie for treatment, and was probably among the first therapy managers and African practitioners who embraced medical pluralism involving both African and missionary medicine. Chitezi, as noted in Chapter 6, was an intermediary and translator who made Steele's medical practice possible in Ngoniland in the 1890s and Mawelera became a leading Christian, evangelist and medical assistant. For his part, Elmslie accepted that Mawelera's heritage enhanced his status as a missionary medical assistant and perhaps quietly recognised that some traditional remedies, as opposed to spiritual treatment, might exist side by side with mission medicine.

In 1900, in an article in the Livingstonia journal *the Aurora*, an anonymous missionary doctor compared the medical missionary and the African doctor in a novel way, emphasising their similarities rather than their differences. The writer was concerned about the future of the mission's medical work, and campaigned for proper hospitals and increased resources for missionary doctors. He argued that medical work broke down prejudice, but, furthermore, that the missionary doctor was also readily recognised by some African people as a healer of the soul, especially by those whose traditional healers' abilities depended on their direct communication with ancestral spirits. The author believed that the medical missionary was instantly recognised by "the native mind" as a medico-religious healer/diviner, and missionaries should utilise this similarity. [52] In this scheme, a missionary doctor was to replace the African healer and establish himself as a scientific medical man with an ability to communicate with God. The problem was how to gain a medical monopoly and not just establish oneself as one healer of the body and soul among many others in the local society. For this, the writer claimed, medical missionaries required well-equipped hospitals, proper operating rooms and surgical apparatus that would make local healers pale in comparison. He did not dwell on the potential further problems of how to combine medical science and religious revelation in practice.

Despite the meagre medical resources the missionary doctors were frequently complaining of, on occasion it seemed as though the African healer had already been decisively defeated in the pages of missionary publications. When Livingstonia celebrated its "semi-jubilee" in 1900, the medical department was praised for not only "opening up" new areas for the mission and awakening "feelings of humanity" among the Africans, but also for breaking up the "power of the witch doctor and the native medicine man", here recognised as two separate entities.[53] It seems that, in practice, the more experienced missionaries were better informed.

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52 *The Aurora*, August 1900, pp. 35-36.
53 *The Aurora*, December 1900, pp. 56-60.

8.2 Psychological interpretations of African practitioners

Both the suspected practitioners of witchcraft and witch-finders were frequently labelled as mentally ill by the missionaries. For instance, in 1925, Wilson complained of an *"insane outbreak of Watch Towerisms"* in Northern Rhodesia, following the witch-killing spree of Mwana Leza (who turned out to be Tomo Nyirenda, a former Livingstonia pupil).[54] For his part, Laws was shocked to hear of killings in Rhodesia and hoped that some of the witch-killers would be executed. For Laws, medical practice and training, especially of hospital assistants, but also instruction in hygiene for teachers, were the prime weapons for attacking the prevailing "witchcraft" model of disease causation. Once "true ideas of cause and effect" were established in the African mind, he believed that the days of witchcraft would be over.[55] Laws instructed Wilson that those church members and catechumens who had joined the Watchtower should be struck off the church roll. They could be individually restored, but only gradually, as joining the movement was *"an indicatic of instablity of character or of ignorance"*, although the terror caused by the popular movement should be taken into account as a mitigating factor, especially for the elderly.[56]

Donald Fraser's stories

The Reverend Donald Fraser (1870–1933) became the most prominent Livingstonia missionary of his generation, and one of the most prolific missionary writers; during the first three decades of the twentieth century he published several books and articles on missionary work at Livingstonia and on the Ngoni, Tumbuka and Senga people. Fraser first arrived in British Central Africa in 1896, and later married a qualified doctor, Agnes Robson. The Frasers worked in uNgoni between 1901 and 1925. Although Peter Forster has, with some justification, pointed out that Fraser's books are more "true adventure stories" than systematic anthropological accounts, Fraser discussed African medical ideas, practices and practitioners in more detail and with more interest than Elmslie. In *Winning a Primitive People,* first published in 1914, he dedicated an entire chapter to "Diseases", in which he dealt with causes of disease, medical practices and practitioners.[57]

Fraser classified five African explanations for sickness and pain, namely (1) natural causes, (2) action of sorcerers using magic or poison, (3) the retributive effects of the sins of others and the work of poison, (4) unfriendly spirits, and (5) demon-possession. Although Fraser claimed those natural causes, or causes that did not involve any magical or spiritual agency, were the least frequent explanations, he actually singled out several common ailments,

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54 Wilson to Laws 2 November 1925. MNA 47/LIM/1/1/35.
55 Laws to Wilson 10 December 1925. MNA 47/LIM/1/1/25 (a), 273.
56 Laws to Wilson 11 March 1926. MNA 47/LIM/1/1/25 (a), 409.
57 Forster 1986, pp. 107-108; Fraser 1922, pp. 139 – 147; Thompson 1995.

such as fever, pneumonia, stomach troubles and toothache, which belonged to this category. "Natural" diseases, or "God's" diseases, therefore included many ailments that accounted for a large number of the cases treated in the mission dispensary, a common pattern in early missionary medicine in Africa, as Ranger has observed.[58]

Fraser argued that Africans had "an immense pharmacy of herbal medicines" at their disposal, and that most people knew some cures, some as family secrets. The examples he cited included specific cures for pleurisy, epilepsy, madness, and childlessness. Although he stressed his ignorance of the exact nature of the herbal medicines used, he stated that *"Most of these herbal medicines have strong purgative or emetic effects, and although I am quite ignorant of their nature, I am bold enough to say that they are not all unproductive of good."*[59]

In addition to non-professional medical specialists, such as bone-setters, Fraser identified a specific African medical profession, the "doctors". Fraser stressed the vulnerability of this profession: to avoid charges of witchcraft or poisoning, the healers must not advertise their craft but gradually build up their reputation. Furthermore, Fraser argued that the "mental influences" of doctors, based on performance, *"songs and dances, incomprehensible incantations… strange dress, clever tricks…"* were designed to win the patient's confidence in the healer. Although Fraser repeated the theme of the African doctor as a clever manipulator, to him the healer was not simply a quack and a charlatan. Firstly, he held that some of the medicines in the African doctor's pharmacy did work. Secondly, the doctors were regarded as "professionals", who specialised in certain forms of therapy. Thirdly, the building of patient confidence using "mental influences" was not negative as such.[60]

It is noteworthy that, in this text, Fraser did not use the word "witch-doctor" at all. When discussing the causes of death, he argued that the same vernacular word, *ufwiti,* could mean both causing death by magic and by "natural" poison. The Europeans, who had translated *ufwiti* as "sorcery" had accordingly absolutely condemned making charges of sorcery and witchcraft. The colonial administration ought to recognise the difference between magic and poison, and not to condemn those who, in fact, suspected that an illness had been caused by poisoning.[61] Fraser's categorisation is problematic, as he tried to delineate a "natural" element within *ufwiti* accusations, while at the same time stressing the importance of "magical" thinking.

The second non-natural cause of illness in Fraser's schema was moral transgression, the "retribution of sins", especially adultery. Adultery was harmful not only to the individual, but also to the health of the community, and could be a serious public health issue. Fraser described in detail a case where he was called to the village of a seriously ill Ngoni paramount. He believed that

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58 Fraser 1922, pp. 139-147; Ranger 1981.

59 Fraser 1922, p. 141.

60 Fraser 1922, pp. 141-142.

61 Ibid., pp. 143-144. Fraser mentions here a case when *"one intelligent boy"* was imprisoned by a magistrate for a considerable time after presenting to Fraser a convincing case for initiating an investigation into poisoning.

the patient was suffering from diphtheria, but the Ngoni were convinced that the adulterous behaviour of one of the paramount's wives was the cause of the illness, and the paramount's "chief induna" made inquiries to find the culprit. One of the wives confessed and was driven away from the village, and "*…with a great load off his mind the induna proceeded to doctor his master. He succeeded in extracting the membrane from the chief's throat by manipulating an oiled feather, and had the satisfaction of seeing him recover…*"[62]

Fraser's eyewitness account provides some important details. Firstly, after the cause of a disease, adultery, had been identified and the culprit punished, the illness could then be treated by medical or surgical means. Secondly, it was the same specialist, the leading *induna,* who was in charge of both operations. Thirdly, Fraser believed that the treatment had been successful, at least partly, because everyone, including the doctor and the patient, believed that the cause of the illness had been located and neutralised. After this, the treatment of the physical manifestation of illness, the membrane in the throat, was "only" a matter of skilful manipulation with an oiled feather. Fraser suggested that it was due to the general alarm and faith in the importance of the confession to healing, that one wife confessed to adultery, whether guilty or not. She stepped forward and was not explicitly identified by any means of divination. As in the *ufwiti* cases, the crucial factor was the criminal, or immoral, action that caused sickness, which might be thoroughly "natural" in its manifestation and subsequent treatment.

This was another case that did not fit neatly into the "natural/magical" dichotomy, and arguably this, in addition to conventional missionary language, is why Fraser uses the Christian term "sin" as the cause of sickness here. For the late Victorian or Edwardian Christian missionary, the idea of moral transgression as a cause of disease was understandable not only on a metaphorical and rhetorical level, but also literally, in cases of venereal disease and alcoholism, for example. The connection between moral transgression and illness provided potential common ground for missionary and African thinking, and Fraser strove to achieve cross-cultural understanding in order to promote African Christianity. However, these attempts were limited by the fact that at the same time Fraser asserted that aspects of African healing were the result of mental disturbance. According to Fraser, a difficult childbirth was commonly regarded to be the result of adultery: in the case of prolonged and difficult pregnancy, the expectant mother was urged to confess the names of her illegal lovers by the "old women" (the village midwives). Fraser accounted for some of these confessions as being the "untruths of hysteria". A Western psychological explanation, hysteria, was invoked to explain African behaviour, and no further discussion of the issue was attempted.[63]

Finally, Fraser identified a distinct specialist, "a doctor of demons"; a spirit possession healer. In Elmslie's earlier classification, as noted above, the communication with the spirit world distinguished the "witch doctor" from

62 Ibid., pp. 145-146.
63 Ibid., pp. 146-147.

those doctors with an inherited knowledge of herbs. Fraser argued that the possession specialist was normally the last specialist to be consulted, after natural causes and magic had been ruled out, and offerings to ancestral spirits had failed to bring relief. He noted there were several types of "demons" (*virombo,* which Fraser translated as "wild creatures") each responding to a particular dance and dress. It was the specialist's job to find out the exact type of demon by trying different drum beats, dances and costumes. After the right form of dance and dress were found:

> ...the sick man became like one possessed. He called for a dress like that of the dancer, and…danced with the exorcist, imitating his steps. The people in the neighbourhood became possessed by the same dancing mania, and they gyrated or leapt about with the sick man, until perspiration poured down his body, and… he had to desist from sheer weakness. That was the last and the final cure. If the exorcism of the demon did not stay the sickness, nothing more could be done, death alone could release the sufferer. [64]

In Fraser's narrative, the dance, the music and dress "possess" the patient and result in the "dancing mania" in the neighbourhood. "Irrational" African behaviour was once again explained in psychological terms. In Fraser's interpretation, some of the African diviners connected to the spirit world were dismissed as hysterics and madmen. However, Fraser also believed that by using local terminology, the missionaries could gradually divert people's attention from "demons" causing physical illness, to a Christian concept of demons causing spiritual injury.[65]

In his later work, *African Idylls* (1923), a collection of earlier articles, Fraser developed his psychological approach to African healing practices, labelling some African practitioners as mentally ill. The devastating influenza epidemic of 1918–19 had caused a health crisis in many areas, and brought local medical responses increasingly to missionaries' attention. In Northern Ngoniland, Fraser wrote:

> Not a village escaped, and in our tribe over two thousand died. Many of those who had been ill lost their mental balance. The sickness found the weakest point in the neurotic African, and attacked his brain. Some wondered about in the bush, mad and restless, and for healing they sought out the witch-doctors. The treatment they received gave some of them power to become witch-doctors in turn, and thus these every charlatans multiplied exceedingly, till they held in their thrall this land...Every night you could hear the rattle of their drums in this direction and that. Sometimes above the exciting insistence of the drums you might hear the distant sound of the chorus the villagers sang, and the nerve racking He! He! of the wizard's yell.[66]

Fraser again mixed new and old elements in his description. On the one hand, he argued that influenza influenced the brains of "the neurotic African", bringing them to, and sometimes turning them into, "witch-doctors". On the other hand, the healers were still referred to as charlatans. In this article, Fraser constantly referred to all local practitioners as "witch-doctors".

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64 Fraser 1922, pp. 146-147.
65 *Report of the Third General Missionary Conference of Nyasaland*, 1910, pp. 30-34.
66 Fraser 1923, pp. 103-104.

The missionaries and the Protectorate officials regarded the situation to be intolerable, as they thought that the search for the culprits of the epidemic had resulted in disturbances in many villages. The colonial authorities and Fraser resorted to propaganda and bluff to frighten the "witch-doctors" into giving up their practice and handing over their instruments. Fraser preached furiously against "witch-doctors" in his Sunday sermon, referring to Levitical law and its death penalty for those who meddled with witchcraft. The Administration stressed the colonial law against witchcraft accusations, and chiefs and village headmen were threatened. Some "witch-doctors" were arrested. Furthermore, the authorities and missionaries issued a strict deadline for the doctors to repent and hand over their instruments, after which all "witch-doctors" would be prosecuted.

As a large number of practitioners lined up to hand over their tools, Fraser had cause to celebrate. He described in detail the instruments that had been handed in: drums, head-dress, bladders, zebra-tails, walnut shells, beads and sticks, bags of roots and medicines. As for the doctors themselves, Fraser described them as mostly "half-insane", many of whom were *"novices whose mental balance had been upset by the influenza"*, including a baptised Christian woman named Jeannie.[67]

The triumphant account continues describing a confrontation between Fraser (who was registering the renounced African doctors) and the leading "witch-doctor":

> "Hullo, old friend," I cried, "have you, too, been hunted out?"
> "I have not practised since the war began," he said. "Well, you did as much evil before the war as a regiment of witch-doctors. How did you come to give up practice?"
> "I was imprisoned, and told that I would get a long sentence if I was found out again."
> "Well, your sentence will be longer even than that if you practice now," I added sternly. "Do you renounce for ever?"
> "Yes," he cried, and I registered.
> "But, sir, I am a doctor now," he volunteered, when I had written his name, "Am I allowed to practice my profession?"
> "What is your speciality?"…
> "I make queen cows to calve, and barren women bear children. My medicine has mighty power."
> "You have only changed the lines of your deception,"…
> "No, sir, my medicine is genuine. Ask so and so, and so and so, if their wives have not borne children since they drank my medicine. I have engagements to go to the Chewa tribe, and to the Chipeta, and my reputation is all over the land."
> "You old trickster, you are still too wise for a credulous people, but there is no law against your skill."[68]

The imprisonment of the old doctor showed that the operation to round up local practitioners was not all bluff. This healer was, however, allowed to defend himself: he argued that he has not practised "illegally" since 1914, and he, in the end, won a concession from Fraser who had to admit, with a certain

[67] Ibid., p. 110.
[68] Ibid., pp. 110-112.

grudging sympathy for the "old trickster" that there was, actually, no law against his skill to practise "genuine" African medicine, with certain specialities. All in all, Fraser recorded that 152 medicine men and women had publicly renounced their craft. Their tools were triumphantly piled upon the communion table in the church, as a visible demonstration of the church's victory, then gathered outside in a heap and burned. However, a number of them were saved by some European "curio hunters",[69] an example of the collecting and classifying nature of colonial knowledge.[70]

Significantly, a later chapter of *African Idylls* contains a section on magic, which adopts a notably different tone towards African healing practices. Initially, Fraser praised and encouraged Western medical missionaries. However, he advised new missionary doctors who might find themselves without African patients, that they would be at a disadvantage initially when they were compared to the local "mighty doctors and magicians", as African practitioners had established themselves in the field first. Furthermore, Fraser stressed that "native doctors" were excellent in their "bedside manner" and painted a humorous picture of how a European doctor could maximise his African attendances:

> … forget the British Medical Association and its etiquette, and open a real magic cave, with curtains, and skeletons, and curious lights, and blood-curling sounds. Wrap yourself in a long coat, covered with cabalistic signs. Put a mighty pair of spectacles on your nose, and waving ostrich feathers in your hair. Dance a little, keep a vigorous jazz band behind the curtain, then dose with the vilest and stickiest mixtures you have, and I shall guarantee you record attendances and marvellous cures. Become a psychotherapeutist, and play on the nerves and emotions of your trusting patients.[71]

Fraser's comedy plays with the idea of the absurdity of a European doctor "going native". However, the only clearly "African" elements in the description are ostrich feathers. Cabalistic signs, curtains and curious sounds and lights come from the European stereotype of a quack or magician, skeletons and spectacles bring an eccentric anatomist to mind, while jazz and psychotherapy were specific to early twentieth-century Western culture.[72]

After this comic relief, Fraser continued in a more serious ethnographical mood, describing the methods of a "great native doctor", whom he referred to

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69 Ibid., pp. 112-113. A more triumphant account of the event is provided by Fraser in *The Record*, October 1920, pp. 180-181.Cf. Fields 1985, p. 121. Agnes Fraser's version of the events is in Fraser 1934, pp. 193-195.

70 In October 1925, during Livingstonia's Jubilee Celebrations, among the exhibits there was a display of "Witch doctor" in his little "spirit temple, with its numerous pots of 'secret medicine'". Visitors included the Governor, Chief Secretary of the Legislative Council and Provincial Resident, who were thus informed of the missionary narrative of African history and the place of "witch-doctors" within it. AUL, MS 3289, Caseby Papers, No. 16. On colonial knowledge production, see, for example, Thomas 1994, pp. 37-40.

71 Fraser 1923, pp. 188- 189.

72 The fear of "going native" was very real in many colonial circles. See Fabian 2000, *passim*. On eccentric anatomists, cf. Jordanova 1989. Both European and African dances were anathema to many missionaries, but not to Fraser; see Fraser 1921.

as "a sort of Harley Street specialist", and whom he dubbed "Sir James" to amuse his British readers. Fraser approached the healer courteously, asking to see his methods of treatment, and followed a procedure where the specialist, "who is called in when the ordinary practitioner fails", was treating the daughter of a chief suffering from *virombo* spirit possession. The treatment included drumming, dancing and sacrifice. Fraser observed that the doctor had "pocketed a good fee" despite the fact that the treatment had failed. The patient said she had not improved, but refused to come to the mission doctor for treatment. To Fraser, the case served as an example of African medical problems that European medicine cannot solve: *"After all, what influence can a little pill have on an evil spirit? It requires more special treatment and a peculiar language. So the girl will not come. Her disease is patent, and it is equally patent that the European has no medicine for such diseases."*[73]

Fraser's fundamental argument was that *"in Africa the master cause of all disease is magic, although there is probably no word in the vernacular just equal to this inclusive word."*[74] He recognised one of the central problems in Western descriptions of African medical practices and practitioners, the problem of translation, but did not dwell on this important issue. He ended up stressing the importance of "magic", stating that all African specialists were "witch doctors" to some extent, and contradicting his earlier statements that *virombo* specialists were only called upon when other treatments, and specialists, had failed.

Throughout this chapter, Fraser avoided the use of the word "witch-doctor". The African doctor was ridiculed, and the absurdity of comparing him with European colleagues was made clear. However, this is only one reading of the text. Fraser, though using ridicule, was trying to make the African realities as he saw them intelligible to an uninformed British, including a medical, audience. He pointed out the limitations of European practice, if African ways of thinking were not recognised. His role in the story was not simply one of a challenging missionary winning over dubious "witch-doctors", but rather that of an interested observer who, while pursuing his own Christian agenda, also displayed some awareness of his limitations. Fraser clearly recognised the importance of rhetoric and the establishment of confidence in both African and Western medical practice, and in this he drew constructive comparisons between the two medical cultures. In this respect, he was almost certainly influenced by his wife's experiences as a doctor in Ngoniland.[75]

Fraser's narratives, in the *African Idylls*, are at some points confusing and contradictory because he pursued different arguments throughout the collection. The figure of the "witch doctor", connected to quackery, superstition or insanity, was usable as an enemy within the missionary chronicles. At the same time, Fraser had to balance this against his personal knowledge that some African remedies worked and were perfectly legal, that African healers could

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73 Fraser 1923, pp. 189-193.
74 Ibid., pp. 193-194.
75 See *Annual Report for 1902*, pp. 38-40.

communicate with their patients in an enviable fashion, and that some of them addressed issues that missionary medicine had no answer or remedy for.

8.3 African Christians and indigenous healers: perceptions and relations in the local community

In *The Autobiography of an African* (1925), Fraser resurrected the "witch-doctor" figure again. This book had a peculiar history. It began as the autobiography of the Ngoni evangelist Daniel Nhlane, written in the vernacular and was finished after his death by his friend, the Ngoni evangelist, and later Reverend, Andrew Mkochi. This manuscript was then translated and edited by Fraser, who contextualised the text with a missionary master-narrative. The story includes an encounter between evangelists Nhlane and Mkochi and "a famous witch-doctor":

> One day they [Nhlane and Mkochi] approached the village of a great witch-doctor whose reputation and wealth depended on keeping the teachers away. He heard that they were coming… and he determined to turn them back with the fearsomeness of his occult powers. Donning all the wild regalia of the full-blown witch doctor he lay in wait for them by the path. Then suddenly the awful figure of the expert in magic rose before them, feathers and bladders and ribbons on his head; bones and stripes of skin about his neck; horns filled with magic across his chest; zebra tails and other oddments fluttering in his hands. With a soul-moving growl he began to dance and point his magic stick at the evangelists.
> But Daniel knew all about it, and he stood on the path and laughed. The wilder the prancing of the doctor grew, the more Daniel laughed, and then he cried to the exhausted magician, 'I have no fear of your horns, nor of any witch-doctor. God alone I fear.'
> Away slunk the defeated doctor and shut himself up in his hut, knowing that his day was over. But not many months went past before a request came from him that he might have school and teachers. When I went there next I found his own stalwart sons the leaders and brightest pupils in the school.[76]

Here the exotic figure of the witch-doctor was invoked in the tale of the victory of an enlightened, new Christian African over the old world of superstition and fear. With the language of derision put into the African evangelists' mouth, Fraser described the total defeat of the "witch doctor". However, the story also tells us that the "witch-doctor" positioned his own sons to lead the new school, a detail which, when compared with the case of the Tembo family, makes possible a new reading which questions the simple tale of the victory of "light" over "darkness". It is impossible to say to what extent this passage was based on the original manuscript. Fraser's narratives can be analysed in detail; on the basis of published missionary texts it is much harder to assess to what extent and how the African evangelists, teachers and medical assistants challenged and combated the local medical practitioners: herbalists, midwives, diviners,

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[76] Fraser 1925, pp. 177-178.

witch-finders and spirit possession specialists. Other sources offer further insights into this complex history, however.

The poison ordeal was one practice that Christians were expected to openly challenge in co-operation with the colonial authorities. In 1907, Laws was informed by MacAlpine that there was an attempt to enforce a poison ordeal at the village of Njonga. The Christians of the village, led by Petros Chanozga and John Ahamanga, an elder and a teacher, defended the accused woman, a catechumen blamed for the death of a child of non-Christian parents. Laws instructed the Christians to protect the woman and prevent the ordeal, and to make clear that the Resident would deal with anyone trying to enforce it. He then informed the Resident at Karonga about the case.[77] Although Laws had often publicly declared that the mission had effectively stamped out the poison ordeal, privately some missionaries believed that it was still commonly practised in the late 1920s.[78]

Marwick noted that some Chewa in the 1950s believed that sorcery had become increasingly common, and this tendency was attributed to European presence in Northern Rhodesia, modern social relationships and increasing differences in material wealth among Africans. In Northern Malawi, a similar theory was put forth by T.C. Young and his informants in the 1920s and early 1930s. According to Central African "moral theory of causation" as outlined by Marwick, the "conservative nature of beliefs in sorcery is thrown into prominence when, as a result of social change, the moral implications of the indigenous philosophy of causation conflict with those of an intrusive one."[79] The mission-educated first- and second-generation Christians were in theory, if not always in practice, representatives of a new "hegemony" (lived system of meanings and values) and active agents of social change at a time of considerable upheaval within Central African societies. They challenged established beliefs and practices, many of which were regarded as being essential to the maintenance of public health in pre-colonial societies. They attacked or refused to participate in spirit-worship, beer-brewing, beer-drinking and dancing (among other practices), and renounced some medical and religious specialists. In many cases, they appeared to have access to new, ambiguous European knowledge and power, as well as new material wealth as a result of their relationship with the mission. When a village community (consisting mostly of non-Christians and a few Christian converts) suffered from illness or death, Christians would arguably be the logical targets for witchcraft accusations.

It cannot be doubted that on occasion there were overt conflicts and that some Christians were accused of witchcraft. For example, in Karonga in 1926, some Christian teachers and evangelists were publicly accused of witchcraft, and one teacher was forcibly dragged from his school by his accusers. Rev. Youngson connected this anti-witchcraft movement to an influential "witch-

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77 Laws to District Resident, Karonga, 29 May 1907. MNA 47/LIM/1/1/9, 278.

78 Youngson to Laws 6 March 1926. MNA 47/LIM/1/1/37; Laws to Youngson 10 March 1926. MNA 47/LIM/1/1/25 (a), 405.

79 Marwick 1970, pp. 281-283.

diviner" at Hebe, in West Nyasa District, and reported that many Christians had gone to consult him. The missionaries informed the authorities, who subsequently sent the Assistant Resident to investigate. Laws encouraged Youngson to pursue the matter, as he believed some of the powerful "witch-doctors" could cause "deadly trouble", and should have "their wings clipped" as soon as possible.[80]

However, in the 1920s, some missionaries had become increasingly interested in, and tolerant towards African healers, traditions and practices. Perhaps the only Livingstonia missionary who in his writings admitted to having successfully tried African therapies was Rev. D.R. Mackenzie, who was in 1912 "cured instantaneously" from a "raging toothache" by an old African healer, who applied a medicine prepared from roots, to the teeth with a leaf. In his missionary-ethnographical work *The Spirit-Ridden Konde*, published in 1925, Mackenzie also mentioned that a senior European in the country was reportedly cured from blackwater fever in 1901 by an African healer, and furthermore, that this European had been provided with a formula for the medicine, which he had later successfully applied in blackwater fever. Although Mackenzie added that another European had been cured of persistent dysentery by an African doctor, he also emphasised that many Africans suffered and died because of inadequate or erroneous treatment.[81] It is noteworthy that of all the missionaries who wrote positively about African medicine at this time (Mackenzie, Alexander Caseby and T.C. Young), none was a doctor. Furthermore, Mackenzie and Young, discussed below, wrote their accounts more as amateur ethnographers and anthropologists than as missionaries. Their writings thus move from the category of "missionary language", a particular cultural position charted by Mudimbe, towards anthropological and ethnographic Western discourse about African people and their beliefs and practices.

Alexander Caseby stated in his autobiographical manuscript:

> The Africans have strange rites, and customs, some are good, some are bad...I had respect for many customs, that saved me from harm many times...I learned from them many customs, met a number of witchdoctors, and experienced many taboos. One man lived on the lake shore. I liked him as a man, but did not approve of his drunken habits, and some evil rites.

Then Caseby described how the warning of this chief, who was a reputed rain-maker, saved him from wandering out into a tornado, and how, in return, the chief asked for a Bible and a cake of soap, and eventually became Caseby's close friend and a Christian. On another occasion, Caseby obtained a recipe *"a witch-doctor used to cure rashes, and kill ticks"* and used it extensively to kill insects threatening his crops. Caseby claimed it *"worked wonders...it cured bean mite, and the butterfly maggot...it worked well on carrot fly and broad bean fly."* In this case, a missionary agriculturalist made empirical experiments in order to apply

80 Youngson to Laws 8 May 1926. MNA 47/LIM/1/1/37; Laws to Youngson 13 May 1926. MNA 47/LIM/1/1/25 (a), 486.

81 Mackenzie 1925, pp. 270-271.

African medicines to horticulture. Generally, Caseby believed that, when treating people, some of the African healers' *"mixtures of herbs, roots, and secret mixtures worked. Other times the patient was doomed to die."* He argued that missionary doctors in the 1920s *"had a good word for some African medicine, some brews from certain tree barks reduces fevers, and root powders, cured dysentery."*[82]

Yet Caseby, echoing the pioneer missionaries, also claimed, in the same text, that the power of the "witch-doctors" had "declined almost to the point of extinction" due to the success of missionary medicine. Furthermore, he described how he personally attacked an alleged "witchdoctor", Mvaro, who was one of his workers, and whom others feared and claimed that he had powers to injure others. Caseby allegedly threw Mvaro's pots at him and destroyed all his "magic gear". When he later spotted the man at worship, he pulled off Mvaro's shirt and announced that *"Mvaro is marked, by his own pots, he is a fake, and a coward, and a cheat"* and dismissed him. In Caseby's tale, grateful Africans told him that many would now sleep peacefully, as they believed that Caseby had broken the spell.[83] In this curious narrative, the truth of which is impossible to discern, it appears that Caseby mixed "witch" or "sorcerer" with "witchdoctor" and by attacking a person with alleged harmful substances and paraphernalia, destroying them and shaming and casting out the "witch", the missionary took on the role of a "witch-doctor", a violent cleanser, himself.

However, direct conflict in the form of witchcraft accusations against Christians or the missionaries calling for colonial police to arrest "witch-doctors" were extreme exchanges between missionaries, Christians and local specialists, and appear to have been relatively rare. In Chapter 11, it is argued that African Christians in general tended towards tolerance and medical pluralism rather than conflict in their attitudes to indigenous medicine. While conflict, in theory, can be defined as "oppositions of principle and motive that are covert, underlying and usually inherent in social structure"[84] and a notable theoretical conflict between African moral theory of causation of illness and misfortune and missionary theories of religion, medicine and holistic health can be discerned, the difference between theory and practice should be emphasised. African medical and religious culture also fostered empiricism, experimentation and pluralism, and in practical quests for health, patients, missionaries and African healers could avoid overt disputes, quarrels and open contest in many ways, often by simply avoiding each others' presence and practice. The missionary archive needs to be supplemented by oral sources to build a more comprehensive picture, however.

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82 AUL, MS 3289, Caseby Papers, Nos. 4, 17-18, 26.
83 AUL, MS 3289, Caseby Papers, Nos. 12, 26.
84 Marwick 1970, p. 284, quoting Gluckman 1955.

Relations in the Khondowe plateau and uNgoni

When the centre of the mission moved to the Khondowe plateau in 1894, the missionaries' new neighbours included a number of recognised African healers. Oral tradition and testimony from the area surrounding the Overtoun Institution offers further insights into the early relations between the missionaries and African practitioners. The informants generally stressed that Laws and the other missionaries did not initially attack local indigenous methods or practitioners overtly, but adopted a more gradual approach, often visiting the sick in their homes and encouraging them to come into the mission for treatment.[85] According to one interviewee:

> It was a gradual process. At first Laws was not hard on them. You know as a visitor he firstly adopted a soft approach, tolerating them to visit the traditional healers. But during this initial period, he used to preach to them the Word of God, bringing to their attention in the process that it was not fitting with the Word of God for them to be consulting the traditional healers.[86]

Preaching and visiting the sick were diplomatic, indirect methods of challenging local medical practitioners. While the people were suspicious of missionaries and particularly of the hospital, medical visits were indispensable opportunities to demonstrate good will and showcase the medical skills of Laws and others.[87] Gradually, missionary attitudes and policies hardened, especially within the Christian community. According to E.K.M. (b.1916) who joined Livingstonia as an electrician in the 1930s, missionaries did not accept local medicine and people could be suspended for taking it. However, they did allow minor cases, such as coughs, to be treated using local methods.[88]

However, the recognition of European medicine by the African public was a slow process. One informant stated that people used to consult both the missionaries and the local healers, but, "they believed the latter's medicine was more effective and that they got cured easier than if they took medicine from the mission hospital."[89] The advantage of European medicine was seen in its exact dosage: advocates of mission medicine argued that in contrast local roots and herbal medicines were often difficult to measure. On the Khondowe plateau, people began to call tablets "the medicine we take with water", and gradually became more impressed with medicine that could be taken in small regular doses, unlike many local medicines.[90] In the view of one interviewee, local medicine was effective, but took more time to work than the white medicine.[91]

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85 Oral testimony, S.M., 8 July 2004; D.C.M, P.L.M.and M.M., 9 July 2004; D.M.M. (b.1923), 9 July 2004.
86 Oral testimony, S.M., 8 July 2004.
87 Oral testimony, D.C.M., P.L.M and M.M., 9 July 2004.
88 Oral testimony, E.K.M., 8 July 2004.
89 Oral testimony, D.C.M., 12 July 2004. One well-known healer mentioned was Chionera Msiska.
90 Oral testimony, S.M., 11 July 2004.
91 Oral testimony, D.C.M., 9 July 2004.

In the Ekwendeni area, people used to local roots as most common form of medicine, were suspicious of the origins of the European medicine, as one informant illustrated: *"Where do they come from? Scotland? So how can we trust their medicine? These may be dangerous drugs. We should still continue with our old ways."*[92] The power of medicines was seen by many to depend upon their land of origin, and the missionary medicines, tablets, bottles and injections, clearly looked different from local medicinal herbs. To some, the difference boosted their power, but to many, this was a cause for suspicion. According to oral tradition, the chiefs in uNgoni played an important role as mediators between Elmslie's early medical practice and the people. Elmslie used to call people to discuss medicine and healing, and explained that his medicines came from factories and were processed in Scotland, and were superior to roots in dose and effect, but he was also willing to hear about African medicine. Most people remained suspicious, but some became interested in mission medicine. The hospital staff and colonial authorities actively promoted and propagated mission hospitals and dispensaries, and gradually the number of patient attendances grew.[93]

In the 1920s, the Mombera Native Association explicitly regarded many health threats in uNgoni as "foreign" diseases coming from distant lands and as the side-effects of "civilization", and increasingly turned to European medicine to combat these diseases.[94] Marwick noted in the 1950s that the Chewa of Northern Rhodesia had often "great faith in European medicines", especially injections, even against those ailments regarded to be the result of sorcery. Marwick quoted one informant: "*God created many trees. There is no reason why the Europeans should not have acquired some of the good trees which can be effective against the bad ones."*[95] African medicines were derived principally from trees and plants, which grew in certain locations. Eventually, European medicines which came from distant lands and in alien shapes became more familiar to Africans and with the increased mobility of people, new illnesses, and new health concerns, African quests for health and the need for medicines spiralled beyond the local communities' resources. The idea that distant lands could have extraordinary medico-religious resources was well known within Central African cultures,[96] and from the turn of the century onwards, the increasing socio-economic pressures of colonialism, new diseases and challenges brought about by migrant labour in particular fostered this development in Northern Malawi.

Missionary medicine became more popular and sought after in this process, but so did new African therapies and specialists. Some African healers selectively appropriated Christian elements in their practice. For example, in the Rumphi district of Northern Malawi, where Livingstonia's influence was strong, the missionaries tried to stop the *vimbuza* phenomenon, but according to

92 Oral testimony, W.C., 13 July 2004.
93 Ibid.
94 Minutes of the Mombera Native Association 26-27 May 1926. MNA S1/1365/24.
95 Marwick 1970, p. 84.
96 Ranger 1975, p. 9.

Karl Peltzer, they "were only successful in integrating Christian elements like quotations from the Bible into treatment sessions and Christian verses into vimbuza songs."[97]

The informants interviewed for this study generally stressed peaceful co-existence, rather than open conflict between Christians and African healers, although they mentioned that on occasion there were disputes, for example in a situation when a sick person's family included both Christians and non-Christians.[98] One informant stressed that "*As Christians we were not encouraged to go to African doctors*", but rather to go to the mission hospital. She mentioned that African healing was problematic for Christians mainly because of the way witchcraft accusations were dealt with and the practice of using chicken's blood as medicine.[99] For their part, some local healers in the Khondowe area objected to the mission and its programmes mainly because of the Christians' condemnation of polygamy.[100]

African practitioners could also criticise and ridicule missionary or colonial medicine, and highlight, for example, the many cases of deaths in the Europeans' hospitals as evidence of the inefficacy of European medicine. In his memoir of medical practice in Nyasaland in the 1920s, W.L. Gopsill, a medical officer, believed that *"The African Witchdoctors are quick to seize on failures. They also have a habit of sending one cases at death's door. Those patients...are too far gone to save. The Witch doctors taunt 'See what happens when you go to hospital.'"*[101] There is no direct evidence of this from the Livingstonia archives, but the missionaries frequently complained that dying cases were sent to them too late, and the doctors also believed that African practitioners were extremely skilful in assessing the severity of an illness. Apart from deaths in hospital, amputations were often resented and criticised by the people, which would have boosted the rhetoric of those African practitioners who wished to contest missionary attempts to establish medical hegemony. The horror stories of witchcraft and cannibalism at the mission stations, which had circulated in the region from the first contacts, could deter people from going to the hospitals, and African practitioners hostile to mission medicine could easily contribute to such tales.

One interviewee argued that missionary doctors not only tolerated, but sometimes even consulted African healers: *"even Dr Laws called African healers to help them* [the missionaries]*"*. This piece of evidence has not been confirmed by any other source, and remains open to speculation. This informant was born after Laws' time, but her family history is strongly connected to Livingstonia. Her father came to Livingstonia for education in the early 1900s, and her older brother was one of the last medical assistants trained by Dr Todd in the early 1930s.[102]

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97 Peltzer 1983.

98 Oral testimony, S.M., 8 July 2004; D.C.M., 9 July 2004; S.M., 12 July 2004.

99 Oral testimony, L.H.T., 6 July 2004.

100 Oral testimony, D.M.M., 9 July 2004.

101 Gopsill, W.L.: "A few notes on my life in Zanzibar and Nyasaland from 1926 to 1945." Rhodes House, MSS. Afr. s. 883.

102 Oral testimony, V.S.K., 11 July 2004. It is possible that in the oral tradition the characteristics of more modern physicians have been attributed to the old missionary

8.4 "Safety-doctor" vs. "death-dealer". Anthropological classifications of Thomas Cullen Young

Thomas Cullen Young (1880–1955) arrived in Livingstonia in 1904 as an accountant and teacher of commercial subjects. Young passed a Tumbuka language test with high marks in 1906, and began his new term as a schoolteacher and became an inspector in 1908. Rising in seniority through the missionary ranks, he was ordained in 1914. From early on, Young developed an interest in the language, history and customs of the people he worked with, particularly the Tumbuka. In 1923, he published his first book on the Tumbuka language and history. With an increasing interest in anthropology, he joined the Royal Anthropological Institute as a Fellow in 1928. He published several articles, and a book, *Notes on the Customs and Folklore of the Tumbuka-Kamanga Peoples* (1931). He resigned from the mission in 1931 and thereafter settled in London, becoming well-known in African Studies circles.[103]

In *Notes on the Customs and Folklore,* Young included a lengthy discussion of local healers, whom he called "medicine men", criticising the use of the term "witch doctor" and the common portrayal of African medical specialists, in clear opposition to Elmslie and Fraser.

> Anyone of either sex can be a "medicine-man,"… the title requires definition alongside that of "witch-doctor" which has come into a very wide and careless use through a rough identification with the South African "smeller-out"… Here in Northern Nyasaland the two words are, ng'anga for the dealer in drugs and charms, mfiti for the "death-dealer". The one friendly and essential to the community's life, the other sinister and shunned, yet tolerated because of fear.[104]

Young argued that Europeans had mixed things up in creating the image of a witch-doctor. To him, the crucial matter in the definition of African medical practitioners was that they deal with difficulties and dangers in a benevolent fashion. Discovering and coping with various threats, overcoming hostile influences and spells, all belong to the scope of "medicine", according to Young. He abandoned as absurd the idea held by Laws, Elmslie and Fraser, that African doctors were essentially clever quacks who exploited the superstitious beliefs of their patients for profit. In his anthropological scheme, this would be impossible, as members of the same "early social group" must share certain common beliefs. Young argued that some African healers inherited their craft, but that ultimately their authority depended on the way in which they worked as intermediaries between the people and higher powers, stressing both religious beliefs and experimental empiricism in African medicine.[105]

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doctors. It is known that in the 1960s, a Scottish doctor in Livingstonia, Dr Irvine, was exceptionally interested in African medicine, and co-operated with local healers, and he is well remembered in Northern Malawi. Interview with Dr Alister Munthali, June 2004.

103 Forster 1989., pp. 7-16, 24-30. For Young's early publications, see Young 1932a-b.

104 Young 1931, pp. 27-28.

105 Ibid.

Wishing to abolish the misleading concept of "witch-doctor", Young argued that the witch-finders should be identified with other "medicine men":

> It is exceedingly hard to say where "medicine-man" and "witch-doctor" part company if the Zulu "smeller-out" is taken to represent the latter class, as is frequently – and I hold wrongly-done. The isanusi, or… vyanusi, are medicine-men in one of the medicine-man's many roles...So far as Northern Nyasaland is concerned, the contrast lies not between "medicine-man" and "witch-doctor", but between what we might call "safety-doctor" and "danger-doctor" ; in other words between ng'anga and mfwiti.[106]

However, Young held that *wafiti,* those who claimed to have deadly or harmful medicines, charms or powers, could be called "witches" as well as regarded as quacks. He translated *wafiti* as "death-dealers", stressing that they were never called *wang'anga*, and were only consulted for killing purposes.

> The ng'anga was the family consultant and essential to orderly living and peace of mind; the mfwiti was the exact opposite… we should apply such evil content as is contained in our word "witch" to the mfwiti and leave open to the "medicine-man" the whole field of beneficial practice, including the "smelling-out" of these anti-social ghouls.[107]

As the "death-dealers" claimed knowledge and powers beyond the "common stock of belief" of the Tumbuka, Young asserted that they were often "cunning men and women" who played upon the fears of the community for profit. He then presented an historical interpretation of the development of the *mfwiti* profession.

Young believed that the nineteenth century, when Arab influences were increasing along with the slave trade, that opportunities opened up for the *mfwiti* who emerged and claimed to have new, deadly knowledge, and exploited the peoples' fears for profit. Unlike Fraser, who suggested that some of the "witch-doctors" and their patients were mentally ill, Young did not offer any psychological interpretations here. Instead, he sympathised with the medicine-men who detected the *mfwiti* for the welfare of the community. The honoured healers were an *"essential link in the community's relationship with the ancestors"*, from whom they had received their valuable knowledge.[108]

For a successful career as a *ng'anga,* self-confidence and astuteness were needed, together with the constant need to deal with social conflicts endangering the community. In divination, in particular, the *ng'anga* relied on careful observation of the client and to "every rumour of the country-side". Furthermore, Young stressed that:

> It would be a surprising list of names if the best-known practicing wang'anga… in Northern Nyasaland were made public. So far from being, as is sometimes said, a practice rapidly disappearing before the advance of civilisation, ung'anga is one of those things which the changing African is carrying over with him from the past.

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106 Ibid., pp. 28-29.
107 Ibid.
108 Ibid., pp. 29-30.

> Such a list would contain names well known in the Teaching profession, the Native Civil Service, and the Church.[109]

Young distinguished professional healers from those who only had medicines for specific ailments. The *ng'anga* was the person needed to provide *"community welfare against unknown forces"*. He pointed out that they could have many roles, including diviner and family doctor. Although he mentioned that some of the healers inherited their craft, he made no distinction, unlike Elmslie, between inherited and other medical knowledge. Young described in some detail the practice of "family doctors" who were consulted in cases of childlessness and mentioned that many children in the Tumbuka-Kamanga area were named after doctors or medicines. He argued that in these cases only a token gift was given to the doctor initially, and that the practitioner would be paid according to results. Young also mentions the "contra-ceptive" medicines, which, in his opinion, were expensive, anti-social and illicit, but did not "come within the limits of *ufwiti."*[110]

Young argued that the belief in charms and spells in colonial Nyasaland was widespread and extended to interpretations of European activities:

> The belief was confirmed in the native mind during the East African Campaign by the fact that most officers carried fly-switches made from the tails of zebra, eland or oxen. This is exactly the method employed by all chiefs for their special charms, and by many private possessors of particular "medicines." The Europeans too, then, carried the charms against death in war! It would surprise most of us to find just how widely this view is held and by whom.[111]

The Europeans carried many items that could be regarded as "charms" or medicines. But they also collected such items from Africans, sometimes by force, as in the case of the healers in 1919 described by Fraser. Young also mentioned that "love-philtres" and *"charms… for the restoration of youth, or at least of youthful powers"*, were traded openly and that some of the "medicine men" in this trade, whom Young claimed to know personally, were of the younger, educated generation, *"the 'changing African' whose mental attitude it is most important for us to understand."*[112]

In Young's narrative, true African healers were anything but quacks. A closer reading suggests that again medical practices were often not straightforward and easy to classify in dualistic terms. For example, the use of contraceptive drugs, which were illegal and "anti-social", but did not belong to the sphere of witchcraft, indicates that the lines of medical activity were sometimes more blurred than Young's basic categorisation of community helper *ng'anga* and anti-social *mfwiti.* The magical activities of *ng'anga* were in some cases dangerous and ambiguous. In his discussion of the magical spells of

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109 Ibid.

110 Ibid., pp. 32, 89-90, 119. Interestingly, Young stated that the anaesthetics used in the European hospitals, though well known, were never referred to as *mgoneko,* but did not reveal what they were called.

111 Ibid., pp. 119-120.

112 Young 1931, pp. 120-121.

ng'anga, Young described protective spells that were designed to punish invaders by unleashing ancestral wrath upon a thief or an adulterer. If such a spell was cast over an area, it could only be lifted by the caster and it could accidentally injure innocent trespassers. Young also noted, like Fraser, that the line between the ingredients of magical and non-magical medicines was "very indistinct". The same Tumbuka verb, *kwambizga*, could be used to decribe magical offensives or poisoning, *"simply attacking one's enemy through his food and drink."*[113] There was also illegal magic, *mgonoko* spells that were used to put people to sleep so they could be robbed, for example. Young claimed that people possessing these "spells" were shunned, and that they are a "sub-species of the *wafiti"*.[114]

Many of Young's comments can be read as a direct criticism of Elmslie's (and, to a lesser degree, Fraser's) narratives, which presented missionaries and the church triumphing over the old superstitions personified by African doctors. He stressed that the profession of *ng'anga,* was a strong, useful, and essential part of the modern African community, and that it was not weakening or vanishing. Furthermore, he hinted that not only was the African medical profession holding its ground, but that its members thrived among the ranks of the Western-educated colonial elite: teachers, civil servants and churchmen of the 1920s and 1930s. His suggestion that there were respected churchmen and mission teachers who were also practising *wang'anga* would have been at least publicly unacceptable to the older missionary guard.

Young held that Tumbuka community life, which was to a great extent upheld by religious and medical traditions, was at its finest before the Ngoni invasion and introduction of wealth through coastal trade. Following the invasion and European colonization, the traditional life had been upset and disturbed. In these circumstances, the harmful "profession" of *mfwiti* had become increasingly prevalent. Communal values had suffered and individualism flourished. As Forster has pointed out, Young's view was probably greatly influenced by his key informants, who tended to idealise the past before the arrival of the Ngoni. The "progress", Young believed, had been *"a movement away from trustfulness towards self-confidence and self-assertion, with a consequent loss on the moral side."* In a "good village", the quarrels were often settled by the *ng'anga,* who adopted the role of an intermediary and provider of counter-medicines against verbal uttered curses. For Young, the Christian groups and individuals were now aiming to restore the situation and recreate a balanced, communal way of life. Young saw the need for *ng'anga* within the African Christian community as well. He argued that the traditional ideal of the "good village", in Christianised form, could engage positively with the interests and concerns of the wider world. This, for Young, could be the great African contribution to the problems of human progress.[115]

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113 Ibid., pp. 111-114; Cf. Forster 1989, p.51.
114 Young 1931, p. 119.
115 Ibid., pp. 146-150; Forster 1989, pp. 46, 61-63.

Peter Forster has argued that Cullen Young's view of African medical specialists differed markedly from that of Donald Fraser, but was not so far-removed from David Livingstone's view.[116] Though it has become clear that the views of Elmslie and Fraser were more negative than those of Young, it is argued here that there was certain continuity in Scottish missionary perceptions. Interest in African medicine, and a belief that some of its treatments worked, did not entirely disappear after the period of "dynamic medical pluralism" in mid-nineteenth century Southern Africa. Robert Laws condemned "dealers in charms" but hoped that African therapies would be studied. Elmslie vigorously attacked local practitioners, but actually admitted that some African treatments worked, and distinguished doctors with inherited knowledge of medicines from "witch-doctors" who dealt with the spirit world. Attempts to categorise African practitioners as either "quacks" or "honest practitioners" marked the writings of Scottish missionaries from Livingstone to Young.

The labelling of the African medical specialists as quacks by Laws and Elmslie was partly due to their background as Victorian doctors, and the particular medical missionary discourse of the nineteenth century. Their attitudes reflected their position as part of the British medical establishment. British physicians and surgeons had recently successfully fought for legal recognition of their profession; unregistered traditional practitioners, midwives and quacks could no longer practice legally. Yet the doctors' position in Central Africa was weak, and they were busy trying to keep the missionaries themselves alive. Any public recognition of African medical skills would have called the value of medical mission into question at a time when one quarter of all European missionaries died due to illness, and could have seriously endangered public support of the mission. It is noteworthy that the pioneer Livingstonia doctors rarely described African healers in psychological terms, in contrast to Fraser's writings.

Elmslie's early attempts to attack medical thought and practice in Ngoni society and replace African doctors with medical missionaries clearly failed. He became one of many medical specialists in a changing society, an experience that was reflected in his attitudes. The relationships between missionary doctors and African healers could be cordial, however, and lead to exchange in many forms, as the case of Elmslie and the Tembo family suggested. What resulted could be a form of dynamic medical pluralism, although most missionaries never tried African therapies themselves.

In missionary publications, the image of the "witch-doctor" was useful and powerful in creating an adversary for heroic missionaries, a representative of superstition and the abuser of the ignorant. This was well recognised by Fraser who, though in some ways had studied African medical practices more openly than his medical colleagues, in some of his publications reduced the "witch-doctor" to a semi-comical figure of the heathen past, fleeing before the light of the gospel. Fraser also introduced a psychological approach to the

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116 Forster 1989, p. 58.

discussion of African healing practices, using terms such as "mania", "hysteria", and "neurotic African" to describe practitioners and patients. As Vaughan has noted, many colonialists in Africa became "self-styled experts on African psychology".[117] Yet some of Fraser's accounts are more ambiguous, and can be read as evidence of complex colonial situations, contests and encounters. The "witch-doctor" who publicly renounced his practice before the missionary in Fraser's tale continues his practice as a fertility specialist.

Young's writings were in many respects a critique of earlier missionary views. However, he also built upon the accounts of Elmslie and Fraser. His book, *Notes on Customs and Folklore,* was not written in the missionary tradition, but using an anthropological approach, after he had given up his missionary career. Consequently, Young's language differed notably from the earlier accounts. When describing African doctors, he used many vernacular expressions, stressing their special nature and the violence that arbitrary translations, such as "witch doctor" inflict upon the actual meaning and use of the words. He emphasised the profession of African medical specialists, aiming to give them respect in the eyes of European readers. Young insisted that the practices of the *ng'anga* were based on traditional cosmology and ways of thought that were essential to the well-being and cohesion of their societies. Unlike earlier missionaries, who were often at best only ready to admit that some of the treatments used by African doctors actually worked, Young argued that the African medical system could be regarded as valid and valuable *as a system* and that it should be respected in the face of modernisation. He saw the failures in the use of the popular concept of "witch-doctor" and attempted to abandon it entirely. However, Young's scheme of classification between "safety-doctor" and "death-dealer", which was intended to clearly define what was "good" and "evil" in the Tumbuka experience of illness and healing, was not unproblematic as a means of explaining and understanding local thought and medical practices. Young did not entirely abandon the concept of charlatan either, but connected it exclusively to the figure of *mfwiti.*

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[117] Vaughan 1982.

9 EXCHANGES, MIDDLES AND NETWORKS: NEGOTIATIONS FOR THERAPY IN THE MISSION HOSPITALS, 1900–1930

9.1 Diagnoses and therapies

In early twentieth-century mission clinical practice, diagnosis was based largely upon a physical examination and short interview with the patient. Patient interviews were often hampered by the doctors' limited knowledge of vernacular languages and African mission "middles" were crucial to successful translation and communication. Agnes Fraser described some of the diagnostic problems she faced in 1902. She complained about:

> the vague and meagre accounts which people give of their illness, whether from lack of observation of their symptoms, or unwillingness to divert one's attention from **the** important feature (to them) of pain, I do not know. [Emphasis original] Often one can learn nothing more than it began "long ago," and that "it aches all over very much". Leading questions often result in wholesale admission or denial of everything. Their great idea is to call attention to the pain and get me to "listen to it," and for that end it is generally described as constant and excruciating, so that my sympathy may be thoroughly aroused. My difficulties in diagnosis are unappreciated by them; for if it is not an ulcer, or an inflamed eye, or an aching tooth, or something else equally obvious, it is "nyamakazi" – a magnificently comprehensive complaint, the one drawback being that it has no one specific remedy…[1]

Fever, chest afflictions (including coughs, pneumonia or bronchitis), ophthalmia, ulcers, various skin diseases, diarrhoea, dysentery, aches in the stomach, head or limbs were among the ailments listed in early missionary writings. Symptoms could be demonstrated or identified visually, either by touch or with the aid of a stethoscope or thermometer, but interviewing

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1 *Annual Report for 1902,* p. 38. "Nyamakazi" is translated by Lwanda as "rheumatism", with general pains all over the body. Lwanda notes that it has frequently been associated with witchcraft, and considered to be a result of nocturnal beating by *afiti.* Lwanda 2002, p. 58.

patients remained difficult. Ailments such as "a common native ulcer" could be visually identified by the doctor.[2]

At the Institution in 1900, most of the patients were pupils or workers in the mission service. The most common complaints included chest afflictions, diarrhoea, fevers, ulcers, skin diseases and injuries from various accidents. Chest diseases were reported to have become more prevalent in the mission by the late 1890s. One theory was that the increased use of clothing by Africans living on the lakeshore was contributing to this trend.[3] On the other hand, missionaries believed that in the case of the Overtoun Institution, pupils' and workers' chest illnesses could be due to their exposure to the cold climate and a lack of warm clothing and housing.[4]

During the nineteenth century and the early colonial period, disease patterns in the Malawi region were undoubtedly changing for the worse. A number of new diseases entered the region, while some previously rare diseases became more common, spreading along trade and military routes as well as through the movement of migrant workers. In the 1890s a skin-burrowing sandflea (known as "jigger"), reached Karonga having been carried by those using the trade routes. Tuberculosis, notably rare in the region during the nineteenth century, became increasingly common after the turn of the century, especially among the migrant labourers who worked in the southern mines. Missionary doctors soon reported cases of both conditions.[5] Sleeping sickness reached the Livingstonia sphere in 1907; the first case was diagnosed by Chisholm in Mwenzo. The first plague cases in the Protectorate were reported in Karonga by Innes in 1916.[6]

By 1914, five out of eight Livingstonia doctors had obtained a Diploma of Tropical Medicine. In line with the general paradigm change from "medicine in the tropics" to tropical biomedicine, mission doctors began to concentrate upon those diseases only diagnosable with the aid of a microscope. By this time, microscopes were more readily available and the younger doctors were more proficient in laboratory work. In 1909, Chisholm listed *"sleeping sickness, phthisis, tick fever, malaria, leprosy, Bilharziasis, Elephantiziasis"*, along with general infant mortality, as the major causes of death and illness that the mission

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2 Chisholm 30 June 1904. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee 1904, pp. 106-107.

3 *Report on Foreign Missions for 1900*, pp. 87-88. Prentice to Smith 20 November 1899. NLS, Acc. 7548 D 69.

4 Elmslie to Smith 31 January 1900. NLS, MS. 7883, 14. *Livingstonia Mission Report for 1899-1900,* p. 4; Laws to Acting Chief Secretary, Zomba, 24 January 1919. MNA 47/LIM/1/1/18, 32.

5 Good 2004, pp. 246-253 and *passim;* King and King 1991, pp. 68-69, 78-79. *Report on Foreign Missions for 1908*, pp. 72-73. In 1899, Prentice observed at Bandawe that tuberculosis was *"conspicuous by its absence."* Prentice to Smith 20 November 1899. NLS, Acc. 7548 D 69. Nine years later, Robertson reported that tuberculosis had become increasingly common in Bandawe and was usually very severe. Robertson 28 February 1908. NLS, Acc. 7548 D 71, Letters to the Sub-Committee 1908, pp. 77-78.

6 Laws 21 July 1907, quoted in *FCSMR,* November 1907, p. 502; King and King 1991, p. 114; McCracken 1982, p. 105; see also Chapter 10.

should address urgently.[7] Sleeping sickness, ankylostomiasis (hookworm) and tick-borne relapsing fever were "new" diseases in Western medicine, identified only after the turn of the century. The symptoms of tick-borne relapsing fever were indistinguishable from malaria. It could only be identified through microscopic analysis of blood film, a practice that was not universally familiar to missionary doctors, even among the younger medical recruits. In 1909, for example, Dr Turner openly admitted his own *"ignorance of the microscopic method."*[8] However, by the early 1920s, microscopic examination of fever patients' blood had become commonplace in the mission's European practice. Innes undertook research into hookworm – which could cause anaemia, debility and, in worst cases, death – in the Karonga district and came to the conclusion that it was far more common than had previously been suspected. Innes also concluded that the prevalence of yaws in the Karonga area was a contributing factor in many other diseases, and that yaws was frequently confused with syphilis.[9] Western medical perceptions of disease and health in Africa were changing: increasingly doctors understood that patients could be suffering from a number of diseases simultaneously.[10]

The doctors' theories about African bodies and diseases were also shaped by their medical and surgical practice. By 1924, Laws had become convinced that "malignant disease" (i.e. cancer), which had previously been supposed to be very rare among Africans, was in fact far more common than missionary doctors had thought. However, Laws still believed that it was not as common in Central Africa as it was in Britain.[11]

Heroic surgery

The attacks of lions, leopards and crocodiles featured prominently in medical missionary narratives, for at least two reasons. Firstly, they provided missionary surgeons with their most challenging professional cases. Secondly, they provided an excellent opportunity to portray the missionary doctors as the heroes of exotic adventures, which was most valuable for missionary propaganda and improved the popular image of the medical missionary. In the 1890s, in Bandawe, as elsewhere, a notable increase in the number of lion and

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7 Mwenzo Report for 1908; *The Livingstonia News*, February 1909, pp. 4-5. *Annual Report for 1914*, list of missionaries from Scotland.

8 *The Livingstonia News*, February 1909, pp. 8-10. King and King 1991, p. 69. Not all stations had microscopes. In 1907, Elmslie sent his microscope from Ekwendeni to Bandawe. Minutes of Mission Council, October 1907. NLS, Acc. 7548 D 71, Letters to the Sub-Committee 1908, p. 16.

9 *The Livingstonia News*, October 1911, pp. 79-80; Laws to Dr Barclay 21 December 1911. MNA 47/LIM/1/1/13, 708; Martin 24 April 1922. Sinclair 2002, p. 56; King and King 1991, pp. 98-99.

10 See Good 2004.

11 Laws disagreed with Wilson's theory that *"specific disease can be set down as the cause of malignant trouble among the natives"*, arguing that the recent cases treated at DGMH did not support such a theory. Laws to Wilson 13 October 1924. MNA 47/LIM/1/1/24, 17.

leopard attacks was reported. This was largely due to changes in the local ecosystem: following the rinderpest epidemic which decimated not only cattle but also game, large predators invaded villages in search of prey. Along with their layman colleagues, the doctors shot and poisoned the beast – activities which could be regarded as public health measures. When the attacks of lions and leopards became rarer in Bandawe late in 1899, George Prentice expressed professional disappointment that *"one fruitful source of surgical cases"* had dried up.[12]

Doctors and nurses occasionally described professionally interesting operations in letters and reports. Hernia operations were among the most complex surgical procedures undertaken in the early 1900s.[13] In 1899, Prentice wrote about a successful surgical case during which he and Innes had removed 272 oz of fluid from a man's abdomen. The fact that this singular case was referred to in the annual reports six years later suggests that the missionary surgeons were struggling to find cases that were both professionally challenging and provided audience-appealing stories of heroic surgery.[14]

Successful tapping produced dramatically visible results, and was an effective way to demonstrate the value and potency of missionary surgery. In 1908 at Kasungu, parents from a distant village brought in their young son who had fallen and hurt his back, which was now swollen. Nurse Henderson reported that the tapping procedure had reduced the swelling and had impressed the boy's parents.[15] However, the prognosis was not always so positive. In 1919 Laws reported taking 92 oz of fluid from a six-year-old's abdomen, but he feared that there was no hope of recovery in this case.[16]

Removing tumours remained an important and professionally challenging part of missionary surgery. The most complicated operations were often possible only when there was more than one surgeon available. When Chisholm visited the Institution in 1907, he and Turner had to remove part of the upper jaw of a patient during on operation to remove a tumour from her mouth.. In 1919 Laws assisted Innes in the removal of a large tumour of the scrotum, and described the operation dryly: *"it was a gory business & we were to the skin with the fluids. The patient is doing well."*[17]

Amputations gradually became more common, and wooden legs were fitted to amputees at the DGMH.[18] According to oral tradition, amputation was not carried out in the Khondowe Plateau region prior to the arrival of the missionaries, and only gradually did the procedure come to be accepted.

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12 Prentice to Smith 20 November 1899. NLS, Acc. 7548 D 69; Livingstone 1921, p. 272; Good 2004, pp. 245-246, 250.

13 See, for example, Annual Report for 1902, pp. 59-60; Laws to Chisholm 3 January 1917. MNA 47/LIM/1/1/17, 755.

14 Prentice 25 May 1905, quoted in *Report on Foreign Missions for 1904*, p. 74.

15 Henderson 18 November 1908. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1909, pp. 9-10.

16 Laws to A. Fraser 31 October 1919. MNA 47/LIM/1/1/19, 304.

17 Laws 23 November 1907. NLS, Acc. 7548 D 71, Letters to the Sub-Committee 1908, p. 27; Laws to Stuart 5 June 1919. MNA 47/LIM/1/1/19, 99.

18 Livingstone 1921, pp. 341-342.

Patients' therapy managers and local healers often objected to amputation. In many cases, patients would be removed from the hospital and treated using indigenous therapies.[19] Furthermore, it was often difficult to keep those patients who had undergone an operation in the mission hospital for essential observation, dressings and recuperation.[20]

Eye surgery

Apart from amputations or the removal of large tumours, the most dramatic form of missionary surgery was performed on the eyes. Missionaries had treated eye ailments, notably ophthalmia, from the early days of the mission. William Scott noted in 1885 that ophthalmia was particularly common at the beginning of the rainy season in November and December. Ophthalmia was also frequently recorded in Laws' Bandawe patient book for 1880–82, and Laws himself was incapacitated by it in 1882. Ophthalmia was treated with lotions and drops.[21] "Eye cases" were, after "ulcers/abscesses" and "skin diseases", the most common surgical case class in Henry's Livlezi valley practice in 1889, accounting for five per cent of all cases treated. Twentieth-century studies have suggested that blindness was exceptionally prevalent in Malawi, especially on the lakeshore and in the south.[22] However, it was not until the introduction of cataract operations at the turn of the century that missionaries were able to perform operations that could dramatically improve their patients' eyesight.

In 1894, Steele performed the first cataract operation in uNgoni. He was confident that its success would bring similar cases to the station. Steele had brought the patient, whom he had met on a missionary tour, to the station to be operated upon.[23] This type of new and (locally) unknown surgery required a remarkable degree of trust from the patient or their therapy managers. By this time, Steele had practised in uNgoni for four years, toured extensively and had built up a reputation for the successful treatment of minor eye ailments. Prentice wrote about a "fairly successful" cataract operation performed at Bandawe in 1900 and asked for a few pairs of spectacles for his cataract patients. He continued to perform cataract operations after moving to Kasungu, and in 1916 reported that he had recently performed five operations, and had three more cataract patients who were waiting for surgery.[24]

However, the most notable eye surgeon at the mission during the early 1900s was Dr Berkeley Robertson, appointed in 1906. Before his resignation in

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19 Oral testimony, P.L.M. and D.C. M. (b. 1920), 9 July 2004.

20 *Annual Report for 1902,* p. 38.

21 Bandawe Station Journal entry for 21 December 1885. NLS, MS. 7911. "Summary of Native Patients, 1882", Daily journal of the Livingstonia Mission, MNA 47/LIM/10/2; Livingstone 1921, p. 211. Livingstone had treated ophthalmia with a solution of nitrate of silver, "two to three grains to the ounce of rain-water". Livingstone 1857, p. 114.

22 *Report on Foreign Missions for 1889,* p. 58; Iliffe 1984, p. 249.

23 Steele to Smith 15 August 1894. NLS, MS. 7877, 110.

24 Prentice to Smith 3 July 1900. NLS, Acc. 7548 D 69; Prentice 4 April 1904. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee 1904, pp. 82-85.

1910, Robertson, who was stationed in Bandawe, performed a large proportion of all the surgical operations undertaken in Livingstonia. Robertson's "latest up-to date fashion" surgical skills were highly appreciated by his patients.[25] Robertson described some of his first cataract patients in Bandawe in early 1908. An elderly woman he had successfully operated upon had travelled forty miles to the station and returned home unaccompanied, dismissing the doctor's suggestion that she should not walk home alone. After a quiet month of minor medical practice, Robertson's next cataract patient and his therapy managers arrived unexpectedly one night:

> There was a dull knocking at door...I opened the door and...asked, "Who are you?" A voice answered, "This is the sick man". I ask, "What sick man?" and the voice answers, "The blind man from so and so." A lamp revealed an old man blind with cataract, who has come in to be operated on. He said that yesterday he travelled on foot down to the lake, and to-day he has come in a canoe. He is not alone, a company of relatives and friends to the number of six being with him. They have all got into a little hut at the back here, really an out-house and not a place for patients at all. They seem quite happy, and as I write I hear them talking in low tones over their fire.[26]

In this instance, the group had travelled for two days, one on a canoe, to Bandawe. It seems that the news of Robertson's treatment had spread a considerable distance within only a month. In September 1908 he recorded that during the past two and a half months, he had operated upon sixteen cataract patients, and that all of them had had their sight restored. The majority of these patients had been blind for several years, Robertson believed. At that time, there were a dozen old cataract patients at the new Bandawe hospital. However, not everyone was either convinced or enthusiastic about the new operations. Robertson quoted one man in Bandawe who *"suggested it would be as well not to have her blind mother-in-law operated on; for, if she saw, he would have to pay the Administration a hut tax for her."*[27] Refusing to consent to an operation could conceivably be a protest against increasing colonial taxation as well as the outcome of strained family relations, or a general suspicion of surgery as perverted body-cutting.[28]

Robertson's eye surgery was an unprecedented display of missionary surgical power with its dramatic, visible, sudden and apparently largely successful results. During 1908, he performed fifty-six cataract operations and sixteen other eye operations, over half of all operations in Bandawe and over one quarter of all operations performed in the mission. The fact that those patients being operated upon were elderly was in itself significant. Old people

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25 *Annual Reports for 1907-1909*; *Report on Foreign Missions for 1910*, p. 116. Cf. Good 2004, p. 270. Prior to his appointment, Robertson had practised at the Ophthalmic Institution in Glasgow. Ballantyne to Daly 1 November 1906. NLS, Acc. 7548 D 71, Letters to Livingstonia Sub-Committee 1907, p. 16.

26 Robertson 28 February 1908. NLS, Acc. 7548 D 71, Letters to the Sub-Committee 1908, pp. 77-78.

27 Robertson 8 August 1908. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1908, pp. 130-132.

28 In Bandawe, colonial taxation was forcefully introduced in 1897. In 1902, there were riots against taxation in uTonga. Chiziwa 1989/1990.

in general were not usually believed to be particularly receptive to missionary initiatives in education, evangelisation or medicine. In many cases, the missionaries held the elderly to be especially hostile to or suspicious of missionary intervention. Arguably, the elderly who had existing kinship and other social networks would have had extensive access to local therapies and usually had few incentives to turn to missionaries in times of illness. However, those who had been blind for years would have probably tried all the available local medical resources in vain, while those elderly patients with a low social standing were often neglected. Blindness could mean incapacitation, social rejection, poverty and death for these patients.[29] Submitting to alien missionary surgery was a risk, but it was a new alternative, and when stories of successful operations began to circulate, several individuals and therapy managers were willing to take that risk. One of the more influential eye surgery patients during this period was Mpangela, M'mbelwa's sister, who became a Christian and whose eye was operated upon by Dr Turner. In 1923, some years after the undated operation, she was reported to be living in Hoho, and could apparently still see well.[30]

Apart from philanthropic and medical reasons, there were clear religious motives behind missionary eye surgery. For the missionaries, this type of surgery had great metaphorical and rhetorical, as well as real, value. Jesus had restored sight to the blind, and missionary doctors could, in some cases, literally do the same. From a practical evangelist point of view, restored vision would enable patients to read the Word of God and receive a missionary education. Robertson wrote that one of his cataract patients had been an old woman who had been blind for about ten years, and had tried to learn at the mission school "by her ears". She appeared to have no relatives, lived on other people's charity, and was brought by MacAlpine to Bandawe. In this case, the missionary took on the role of therapy manager, but the majority of cataract patients appear to have been accompanied by their own relatives.[31]

Robertson argued that restoring sight to the blind was no more expensive than providing a cough mixture, although it was significantly more exciting for the doctor.[32] However, the cataract operation was not without its risks. While congratulating Agnes Fraser on her eye surgery in 1919 Laws admitted that he personally had longed to *"have the privilege of giving sight to the blind"* but that his only cataract operation had failed, with the patients' *"fingers going where they shd. not have been"*.[33] The operation required both the steady hand of the

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29 *Annual Report for 1908*, pp. 40-44. Good 2004, p. 245; Iliffe 1984, pp. 246-249.

30 Stuart to Laws 3 May 1923. MNA 47/LIM/1/1/44.

31 Robertson 8 August 1908. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1908, pp. 130-132. Prentice reported in 1901 that after he had preached at Kasungu about Christ healing the leper and restoring sight to the blind, he was approached by a woman with leprosy and an old head-man with a cataract. However, when Prentice told the man that he had *"no medicine to cure him, but could operate"* the headman retired to his hut in horror and refused to see the doctor again. *Annual Report for 1901*, p. 25.

32 Robertson 7 September 1908. NLS, Acc. 7548 D 71, Letters to the Sub-Committee 1908, pp. 130-132.

33 Laws to A. Fraser 1 October 1919. MNA 47/LIM/1/1/19, 260.

surgeon and a trusting, unmoving patient. In the early 1920s, Agnes Fraser declined to operate on an elderly white settler, as her previous cataract operation had been a failure and she felt unsure of her hands. In 1922, Prentice feared that he had damaged one patient's eye owing to the lack of light in the hospital. The ageing missionary surgeons felt increasingly unsure of their skills.[34]

Surgery demanded that both the patient and the patients' therapy managers submit completely to the will of the healer during an operation. It required considerably more trust in the healer than a treatment using medicines. The surgeon, patient and therapy managers had to form a deeper working relationship than those formed in outpatient practice. As the mission hospitals developed with separate operating theatres and in-patient wards, the patients were increasingly isolated from their therapy management group. To make communication, trust and co-operation possible, the mission hospitals depended heavily upon African medical "middles" – medical assistants and nurses.

9.2 The emergence of medical "middles"

Early assistants

Medical assistants or "dispensary boys" had been helping the Livingstonia doctors from the early days of the mission. They were taught on the job and their instruction, skills and period of service varied. Some of them were very young, like Charles Domingo, who had been Laws' "hospital boy" before becoming a leading theological student at the Institution, a prominent elder and evangelist, and later an independent church leader. In Karonga, Cross' assistant "Pondhani" or "Pondemare" was a trained chloroformist and worked with Cross for at least seven years. He was Cross' personal servant, and one of the first two baptised Christians at the station. The early assistants' main dispensary duties were dressing ulcers and wounds, distributing medicines from prepared stock-bottles, interpreting and providing general assistance to the doctors. The mission employed eight assistants in 1902: three at the Institution, two at Hora and the remaining three at Bandawe, Karonga and Kasungu stations.[35]

In Bandawe, Stefano Potifar Mujuzi Kaunda (d.1911) was a long-serving medical assistant who was under the supervision of several doctors and worked alone between 1899 and 1911. A former orphan and slave from the village of Mchaya near Bandawe station, he was raised as the "house boy" of a

34 Prentice to Laws 30 September 1922. MNA 47/LIM/1/1/39; Martin 7 September 1924. Sinclair 2002, p. 204; Laws to MacAlpine 27 May 1920. MNA 47/LIM/1/1/19, 671.

35 *FCSMR*, September 1903, p. 409; "Karonga Report for 1895." NLS, MS. 7879, 43; *The Livingstonia Mission Report for Year 1893-94*, p. 11; *Annual Report for 1902*, p. 66.

missionary. He then became a teacher, a baptised Christian, elder and a preacher, and was in mission service from about 1890. He held the office of elder from 1895 until his death, and in the late 1890s he was a pioneer teacher-evangelist in Kasungu among the Chewa. He first became a dispensary assistant under the supervision of Prentice, after he received the highest marks in the teachers' examination.[36] Kaunda was already an experienced teacher-evangelist when he became a medical assistant, which made him an ideal medical evangelist. He refused an offer to become medical assistant on a rubber estate where the salary would have been thirty shillings per month – almost three times higher than his pay at the mission. Boxer considered him *"as useful to me as another European would be"*, and stressed that Kaunda should be paid the same as the trained teachers and preachers from the Institution. His duties included the dispensing of medicines, dressing of ulcers, vaccination and administering chloroform. It seems that Kaunda viewed his medical work as his duty as a Christian and a prominent member of the Bandawe congregation, rather than simply as a career for material gain. Kaunda fell ill and died in 1911, after treating pneumonia cases at the Bandawe hospital at a time when there was no doctor at the station. During his long career, Kaunda's medical and surgical skills had been highly appreciated by a succession of missionary doctors.[37]

John Iliffe has argued that most of the first East African practitioners of Western medicine were young men who had been uprooted from their traditional societies. Before the introduction of Western medical education for Africans, they worked as apprentices under the supervision of missionary doctors. Apprenticeship was also the prevailing model of indigenous African medical training. However, under European tutelage the assistants had no opportunity to qualify as independent practitioners who would be accepted as equals by Europeans. According to Iliffe, the first African medical assistants had few connections with traditional healers.[38] Some of the early assistants at Livingstonia (including Domingo and Kaunda) fit well into Iliffe's scheme. They had become dependants of the mission during their childhood or teens and their relationship with local healers remains unknown in most cases. A notable exception was Mawelera Tembo in Njuyu (as discussed previously). His status as the son of a local healer reinforced his reputation among the people in the late 1890s.[39] However, there are no subsequent references to his medical practice within the Livingstonia records. Tembo became a prominent church elder and a respected evangelist; in all probability he may have

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36 EUL, MacAlpine Papers, MS. 3086.2.; Minutes of the Mission Council 19 October 1911. MNA 47/LIM/3/17; *The Livingstonia News*, October 1911, pp. 73-77; *FCSMR*, July 1897, pp. 168-169; McIntosh 1993, pp. 130-131.

37 EUL, MacAlpine Papers, MS. 3086.2.; *Report on Foreign Missions for 1912*, p. 105; *The Livingstonia News*, October 1911, pp. 73-77; Prentice to Barbour 18 September 1900. NLS, Acc. 7548 D 69. Letters to the Livingstonia Sub-Committee, 1898–1900, 99; Boxer to Overtoun 5 November 1901. NLS, Acc. 7548 D 70; Rennick 2003, p. 209.

38 Iliffe 1998, pp. 7-19.

39 *Report on Foreign Missions for 1897*, pp. 95-96.

continued to practise minor medicine in Njuyu, but not as an official medical assistant of the mission.

Formal training

Laws had envisioned medical training that would eventually result in a medical school for “Native Medical Missionaries in Central Africa”, but formal medical education emerged slowly. A major impetus for the establishment of a formal medical course came from Blantyre, where Dr Neil MacVicar had started an advanced course of medical training in the late 1890s. In 1904, the Livingstonia Institution course was “formulating”. Theoretical instruction was given in English. Headmaster Henderson stressed that the course would need to be developed cautiously, in the view of the “obvious” dangers. These dangers included giving pupils too much medical knowledge too soon, loss of missionary control, and the possibility that influential Western medicine might be taught to non-Christian pupils. The missionaries were well aware of the secularising potential of medical education in Scotland.[40] The aim of medical education was to train Christian assistants, who would eventually carry the medical missionary project further into the expanding mission sphere. However, they were to remain strictly subordinate to Europeans. Laws assured the Acting Commissioner of the Protectorate, in 1906, that the medical course was only for approved pupils, who were trained to assist European “medical men”.[41]

Even after the medical course at the Institution was launched, most of the medical assistants were first trained on the job at the Livingstonia out-stations. The doctors, and later nurses, gave basic medical instruction to assistants and mission teachers as time permitted. Some of them were later sent to the Institution for further education. In 1907, after he had been successfully examined by four mission doctors, Stefan Kaunda was given a special certificate and his salary was increased to twenty-five shillings a month.[42] During the absence of a doctor or nurse, the trained assistants would take charge of hospitals and dispensaries, sometimes with notable success, including Daniel Gondwe (an Institution-trained assistant) who took charge of Ekwendeni hospital during 1909.[43]

In 1909, the Educational Board of the Nyasaland Missionary Conference agreed on a framework for medical education in the Protectorate. It was

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40 “Memorandum regarding the Organisation and Development of the Livingstonia Mission”, printed in *The Livingstonia Mission, 1875-1900*; *Annual Report for 1904*, p. 14; Henderson 10 January 1904. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee 1904, p. 43; *Report of the Second General Missionary Conference,* 1904, pp. 28-29; Rennick 2003, pp. 75-76; Ross 1988.

41 Laws to Acting Commissioner 16 February 1906. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1906, pp. 39-42.

42 Minutes of the Mission Council October 1907. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1908, p. 8.

43 See, for example, *Annual Report for 1900,* p. 22; *The Livingstonia News*, February 1910, pp. 7-8.

decided that the medical courses should lead towards two grades, "Hospital Orderlies" and "Hospital Medical Assistants", which would be recognised by the government. The two-grade policy was followed in the Institution after the war. The course fees were set at twelve shillings per annum for orderlies and twenty shillings for assistants in 1911. Married medical students and their wives, who had travelled some distance, would be provided with food for the first year of their studies. After that time, they would be expected to grow their own food in the mission grounds.[44] In the late 1920s, the medical course lasted for four years, with each year being divided into two terms. Each year, the assistants studied for six months and the orderlies for three.[45]

As Maryinez Lyons has noted, "a medical system can be a potent means of controlling the *total* person, mind and body; consequently access to medical systems is often jealously guarded." The missionary doctors aimed to establish a professional monopoly for Christian African practitioners of Western medicine, which was to be protected by colonial authorities. Laws was especially prominent in pursuing this aim. As a member of the Protectorate Legislative Council between 1913 and 1916, he worked to secure official recognition and registration for mission-trained assistants. Thus, the certified trained assistants were recognised and registered by the colonial regime. For Laws, this was essential step towards creating a Christian African medical profession under missionary supervision.[46]

It was crucial that the medical students were of good "Christian character". Laws held that the spiritual and moral condition of the medical students should be even more strictly supervised than that of the theological students: "*the temptations to go astray would be far greater for a native medical than for a native pastor.*" Laws believed that in future, African assistants would be in charge of dispensaries and hospitals at new stations alongside an ordained European missionary resident, and where the Europeans at the station would be unlikely to need any medical assistance. African assistants were only supposed to treat other Africans, and always under supervision, although the European medical missionary could supervise medical assistants from a distance. The more difficult cases would always be sent to a European doctor.[47]

Only two medical students were undergoing training in 1911. The next year Laws asked whether any station had teachers with an "ability & desire" for medicine. He wanted to recruit married Christian men who had their probationer's certificates and had been "well tried".[48] The number of trainees gradually increased but changes in mission staff and the First World War

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44 *The Livingstonia News*, October 1910, p. 85; Laws to Principal Medical Officer, Tanganyika Territory (n.d.). MNA 47/LIM/1/1/25 (a), 45; Overtoun Institution Senatus Minutes 14 March 1911. MNA 47/LIM/3/32.

45 Laws, "Native Education in Nyasaland". MNA 47/LIM/4/2.

46 Lyons 1994, p. 204; Proctor 1989, pp. 79-82. In the Legislative Council formed in 1908, the Scottish missionaries were given a seat on the understanding that they would represent African interests.

47 Laws 20 June 1906. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1906, p. 100; *Annual Report for 1906*, p. 17.

48 Laws, "Circular Note to Stations" 2 November 1910. MNA 47/LIM/1/1/13, 94.

disrupted courses. Once the training resumed after the war, each course for hospital assistants lasted three years. Four students preparing for their final examinations (two for the Hospital Assistant and two for the Hospital Orderly grades) in September 1926.[49]

Medical assistants were expected to be married Christian men with "tried" character and abilities; marriage was deemed to be a crucial component of (African) moral health. Access to Western medical knowledge meant access to power, and Laws greatly feared the corruption of medical power, which is why he believed that medically trained Africans were subjected to even greater "temptations" than African pastors.[50] To Laws, a western-educated "witch doctor" practising without missionary supervision was an anathema. An independent healer advertising Western medicines could potentially establish a lucrative business that could compete with and challenge missionary medicine. In the early 1900s there was little formal control and supervision of medical assistants in the colonial and settler service.[51] Furthermore, medical assistants were sometimes in intimate situations with female patients, which was (in the missionaries' eyes) potentially morally dangerous and corruptive. The morality of the assistants was to be rigorously scrutinised, and no serious "lapses" were to be tolerated. When Daniel Gondwe was condemned because of his polygamy, Laws' judgement was that he *"must always be looked on as unstable"*.[52]

The colonial government and the European companies could offer a better salary than the mission could to trained assistants, which was another reason why the missionaries wanted only loyal Christians to undertake the medical course. However, not all of the assistants or orderlies were satisfied with mission requirements or their terms of service. Some resigned, and others were fired. In 1907 Elmslie clashed with the Institution-trained assistant Isaac in Ekwendeni. According to Elmslie, Isaac refused to take up office work in addition to his medical duties: he seems to have been a skilful assistant with professional pride. Elmslie demanded total obedience from his assistant and help in any duties that he (Elmslie) deemed to be necessary. Elmslie argued that medical practice in the dispensary usually took only a couple of hours a day,

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49 Laws to R.R. Murray 23 December 1925. MNA 47/LIM/1/1/25 (a); Laws to Ashcroft 7 September 1926. NLS, MS. 7889, 75.

50 Laws to Principal Medical Officer, Tanganyika Territory (n.d.). MNA 47/LIM/1/1/25 (a), 45.

51 According to Elmslie, in 1907 in Fort Johnston a totally unskilled "boy" had bluffed his way into highly paid Government medical service. Elmslie to Laws 19 June 1907. NLS, Acc. 7548 D 67.

52 Laws to Stuart 13 January 1920. MNA 47/LIM/1/1/19, 411. In 1914, Laws wrote to a missionary in Belgian Congo in response to a query about a former Livingstonia pupil, Thomas Rufu, who was seeking employment there. According to Laws, Rufu had passed the teachers' course at the Institution, taken up the theological course, but was suspended after having being convicted of sexual immorality. Eventually, Rufu left the mission and worked in various jobs. Alarmingly for Laws, *"He even tried his hand as a native doctor, making gynaecology his speciality, the last thing it was safe for him to meddle with & for which he had no instruction."* It is unclear whether Rufu was applying for a clerical or a medical post in the Congo, but Laws' fear of a mission-trained "quack" is clear. Laws to Springer 5 November 1914. MNA 47 LIM/1/1/16, 102.

and it would be impossible to let Isaac "go idle" with his salary of twenty-five shillings a month. In the end, Isaac resigned, demanding a certificate of his employment. Elmslie, who appreciated Isaac's medical skills, hoped that he could be persuaded to work at another Livingstonia station, but he doubted that Isaac would be willing to do this. He advised Laws not to give a very high certificate to Isaac because of his insubordination. According to Elmslie, the government paid thirty-five shillings a month to a hospital assistant at this time, and there was a high demand for trained assistants.[53]

Laws was worried that the position of mission-trained assistants could be threatened in the future with the arrival of Indian "Sub-Assistant Surgeons". In 1914, the Legislative Council planned to amend the Medical Practition and Registration Ordinance to create a second class of registered practitioners – sub-assistant surgeons between European doctors and African medical assistants. Laws initially opposed the bill and fought for amendments in the fear that in the future African assistants might be "swamped" by Indian sub-assistant surgeons in the hospitals of the Protectorate.[54] There is little doubt that religion was at the heart of Laws' concern about Indian practitioners working in Nyasaland.

Laws was approached by the Principal Medical Officer of the Tanganyika Territory in 1925, and was asked about the capacity of the Institution to train dispensers and assistants for the colonial medical service in Tanganyika. A number of Livingstonia-trained assistants had been employed there, and they had made a favourable impression. Laws was interested in the prospect of establishing long-term co-operation, although he could not offer immediate candidates immediately. He stressed the damage that war had caused to the mission's educational programmes. As a result, there were not enough pupils who had sufficient training in English (required at standard six) to begin medical training. Furthermore, without the sanction of the Nyasaland authorities, the mission could not train pupils for work outside the Protectorate.[55]

Trained assistants

Between 1920 and 1926 Livingstonia recorded the employment of between eight and thirty-two "assistants" annually at its stations in Nyasaland, Northern Rhodesia and the Tanganyika Territory, but these figures may have included assistants, orderlies and African nurses as well as Overtoun medical students.[56]

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53 Elmslie to Laws 12 and 19 June 1907. NLS, Acc. 7548 D 67. At this time, average wage for African labour in Nyasaland was around three shillings per month plus food. Iliffe 1984, p. 261.

54 Laws to Elmslie 4 April 1914. MNA 47/LIM/1/1/15, 662.

55 Laws to Principal Medical Officer, Tanganyika Territory (n.d., 1925); Laws to Wilson 10 December 1925. MNA 47/LIM/1/1/25 (a), 45. 273.

56 *Reports on Foreign Missions for 1920-1926*. The exceptional figure of thirty-two was reported during 1924, with sixteen assistants at the Institution. This figure must have included the medical students.

Of the Institution-trained medical assistants, Yoram Nkata from the Bandawe congregation worked both at the Institution and at Bandawe. He was one of the first medical students to qualify, and had finished his course by 1907, when he was working at the Institution hospital. Laws and Nkata remained in correspondence while Nkata was away from Livingstonia. In 1913 he was back with his family in Bandawe and was assisting Dr Turner at the station, but he apparently wished to return to the Institution. When the war broke out, Turner could not spare Nkata for colonial military service. Nkata was once again working at the DGMH in 1920, where he was highly appreciated by Laws both as a capable assistant and as an active preacher.[57] He subsequently returned to Bandawe, and in 1922 he was reported to be ably assisting Turner at the Bandawe hospital as well as conducting church services. Nkata was approached in cases of difficult childbirths as well as in the treatment of infants, and was called upon in maternity cases more often than the European nurse. The fact that in late 1922, both the European doctor and the nurse at Bandawe were living nearly three miles away from the hospital added to Nkata's independence in practice, and in 1924 he was in sole charge of the hospital. Nkata, who prescribed medicines for the European missionary at Bandawe, was regarded as a respected role model for younger Bandawe students at the Institution.[58]

Nkata fell seriously ill during 1925 and was treated in Bandawe hospital. He suspected that he was suffering from "an aneurism of the right carotid artery" but Laws disputed his diagnosis, arguing that such an aneurism was very rare in the country, and assured Nkata that he would be likely to improve soon.[59] Nkata clearly had access to medical books at Bandawe. According to Mamie Martin, during the previous year the doctors at the DGMH had eventually agreed with all of Nkata's diagnoses of six patients he had taken to the DGMH – including a complex case which had puzzled the doctors. He recovered from his illness in 1925 but died three years later, reportedly of blood poisoning and an abscess in the brain. Nkata's death was followed by large-scale public mourning in uTonga, and his funeral was reported to have been attended by around 4,000 people.[60]

Nkata (like Stefano Kaunda before him at Bandawe) Fred Nyirenda at Karonga and Moses Kasoma at Chitambo were all church elders as well as medical assistants. In 1926 Moffat described the career of Kasoma in the Chitambo congregation. A Biza from the village of Kalonde, Kasoma first attended the mission school in his village, then enrolled as a "hearer", became a school monitor and after two and half years qualified as a village school teacher

57 *Annual Report for 1907,* p. 8; Laws to Nkata 27 February and 25 September 1913; Laws to Stannus 13 September 1914. MNA 47/LIM/1/1/14, 52, 394, 967.Livingstone 1921, pp. 365-367.

58 Mamie Martin 10 and 23 January, 20 February, 29 June 1922; 18 December 1923; Jack Martin 19 August 1923. Mamie Martin diary entry 21 December 1923. Sinclair 2002, pp. 36-37, 40, 73, 148, 171.

59 Laws to Nkata 28 December 1925. MNA 47/LIM/1/1/25 (a), 300.

60 Mamie Martin 25 September 1925; Jack Martin 4 June 1928. Sinclair 2002, pp. 206, 326-327.

and a catechumen, and was eventually baptised as a Christian, taking the name Moses. After the death of the chief of Kalonde, Kasoma was chosen as his successor, but according to Moffat, was rejected as he refused to marry the deceased chief's wives. He remained a teacher, and after a few years was elected as an elder of the Chitambo congregation. He eventually became a hospital assistant and Dr Wilson's "right-hand man".[61] After the war, assistants took over medical practice for lengthy periods of time in Bandawe and Karonga, among other stations.[62]

Nursing

The medical education in Livingstonia envisaged by Laws was the reproduction of a Christian medical missionary as an African medical evangelist. This was clearly a programme for the training of Christ-like men. However, at the same time the missionaries considered nursing to be part of the natural feminine sphere, essential for Christian womanhood. From early on, the missionaries were assisted by African women in the nursing of the in-patients. They remain usually nameless and only occasionally surface in the missionary publications. In 1909, for example, *The Livingstonia News* mentioned a new "female assistant", doing "excellent work" at the Overtoun Institution hospital.[63]

In 1908, Bandawe hospital was staffed by Stefano Kaunda and "a native Christian woman", who helped the female patients in particular. She was learning to dress ulcers "and such like work", and Robertson trusted that in a case where both the doctor and assistant were away she would be able to maintain the hospital.[64] It is possible that this person had been described by Donald Fraser in 1901 in an illustrating example of how missionaries represented African Christian women in missionary propaganda:

> There is one Atonga woman who is very conspicuous about the Bandawe station. Her women's class is the largest and most interesting. She is matron at the dispensary and the temporary hospital…She is a widow, a great woman among her people. She was leader and initiator in the foul pagan ceremonies of her people. No one knew better than she the superstitions and the claims of their traditions. But to-day she is a mother in Israel, washed and made clean by the blood of the Lamb.[65]

For Fraser, conversion to Christianity had spiritually and physically cleansed an influential widow and leader of initiation ceremonies and transformed her into a matron, teacher, and cleanser. If Fraser's narrative was based on a real person and her background was described accurately, she would have been familiar

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61 Moffat, "Chitambo Trophies", *Other Lands* July 1926, pp. 125-126.

62 Laws to Faulds 30 January 1927. MNA 47/LIM/1/1/25 (a), 777. It seems that Fred Nyirenda in Karonga made a favourable impression upon Rev. Faulds, as Laws had to correct Faulds in his compilation of medical mission statistics in 1927, when Faulds had classified Nyirenda as a "native doctor".

63 *The Livingstonia News,* February 1909, pp. 8-10.

64 Robertson 7 September 1908. NLS, Acc. 7548 D 71, Letters to Livingstonia Sub-Committee 1908, pp.130-132.

65 Fraser 1901, pp. 30-31.

with local medical practices especially those relating to childbirth. It is known that there was an elderly woman nurse assisting in the Bandawe dispensary, and it has been noted earlier how Prentice's obstetrics practice had increased in the 1890s before the appointment of Stefano Kaunda as an assistant.[66]

At the Overtoun Institution, an African nurse, Marie, was an important member of the medical staff during the early 1900s. Nurse Ballantyne described the duties of the staff during the amputation of a leg in 1906:

> Miss Fiddes gave the chloroform, assisted by our native nurse, Marie, who held the bottle, &c. Dr Laws did the operation, assisted by Dr Robertson. The two boys looked on, while I acted as instrument clerk and swabber.[67]

It is unclear whether "Marie" who assisted in this operation was Maria Chilimbnano, an elderly nurse at the Institution who died in 1914. Fiddes had mentioned Maria, an "old faithful Christian woman" at the Institution as early as 1904, and she had been resident for a long time prior to that. Nurse Chilimbnano's effects comprised a little over three pounds and two baskets of peas.[68] According to Livingstone, she was an orphan and a former slave, who had become attached to the mission in old age, attended evening classes and learned to read. Becoming a mission nurse enabled Chilimbnano, a former outcast from society, to assume in her old age a role similar to that of the respected African midwives.[69] Another early nurse known by name was Philomeia Hockel, whose father was a German, and who was sent to be educated at the Institution c. 1913. Four years later, she was working as a nurse and being trained at the Institution. In 1920 the DGMH employed a total of three African nurses. They wore a distinctive uniform: overalls and apron worn over a khaki dress trimmed with red.[70]

Although African women had been quietly working in the missionary dispensaries and hospitals from their inception, some missionaries and other European mission employees dismissed these women's capabilities. In 1904 Miss Dewar, a Scottish nurse at Blantyre Mission, expressed surprise that African women were teachable at all, and argued that it would take years before the training of nurses would be possible.[71] Her racist views can be viewed as rhetoric employed to defend the status of the white nurse at a time when missionary hospitals were emerging as more organised entities. If nursing was not a "natural" sphere for all women, but rather for "civilized" European middle-class women, it would remain their privilege as defined by race and class. The views of Livingstonia missionaries in this respect are unclear, but it is clear that higher medical education at the Institution was initially restricted to

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66 *Report on Foreign Missions for 1896*, p. 101; Prentice to Smith 24 June 1895. NLS, MS. 7878, 200.

67 Ballantyne to Daly 1 November 1906. NLS, Acc. 7548 D 71, Letters to Livingstonia Sub-Committee 1907, p. 16.

68 Laws to Prentice 10 and 13 October 1914. MNA 47/LIM/1/1/16, 47.

69 Livingstone 1921, p. 342; Good 2004, p. 349.

70 Laws to Ross 14 February 1917. MNA 47/LIM/1/1/17, 842; Livingstone 1921, p. 365.

71 *Report of the Second General Missionary Conference,* 1904, pp. 70-72.

men. African nurses were taught on the job in the hospitals and the health education of women was promoted, but access to professionalized Western medical knowledge, status and European medical power was reserved for Christian men in Livingstonia. However, in 1924 Laws wrote to the Attorney General advocating the registration of trained African nurses, in order to give them official standing in the country. Although they could not be included in the Medical Sub Register, Laws admitted that, *"they are in a way as useful to the community as Hospital Assistants we are training"*.[72]

It has been noted that the gendered role of the colonial African medical assistant was somewhat unclear. They were men, whose tasks mainly consisted of nursing duties, which for Europeans was a feminine activity.[73] Their training at the Overtoun Institution aimed to make them Christ-like masculine evangelists, but in reality they were subordinate not only to European doctors, but also to white female nurses. At the same time, as members of the Christian community they were expected to become patriarchal heads of family. The missionaries themselves propagated patriarchal values in their home life and doctor–nurse relationships.

For the assistants from uNgoni, the situation seems to have been particularly difficult. In the absence of a doctor at the Institution in 1921, two Ngoni assistants refused to take orders from a European nurse. In Ekwendeni in 1926, an elderly assistant resented taking orders from Mrs Treu, a nurse who had only recently arrived at the Institution. Charles Stuart (echoing Laws) explained this incident as an example of *"Ngoni spirit of resenting being dictated to by a mere woman"*. Matters came to a head when Treu asked the assistant, Timon, to sleep in the hospital and watch over a patient. He refused twice and was fired by Stuart on the spot, which left Treu alone and unable to communicate with her African patients in a full hospital. Treu hoped to train a local woman as a nurse and a suitable candidate had been found, but it would take time some before she could come to the hospital. Stuart asked if Laws could send Maria Gondwe (a nurse from Ekwendeni district who was working at the DGMH) to help. However, as her services were offered for only a month, and the Ekwendeni funds did not permit the employment of a fully trained hospital assistant, a local nurse training arrangement was preferred.[74]

By the mid-1920s, then, some of the mission stations did not have enough money to employ the mission-trained assistants, and there was no formal training programme in place for African nurses. In 1924 Laws had to inform the Indian Sub-Assistant Surgeon in Mzimba that there was no "female native nurse" in Livingstonia available for employment at the Mzimba hospital. However, in 1926, a formal training scheme for nurses at the DGMH, designed by Nurse Patrick, was approved by the Mission Council. Candidates needed to

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72 Laws to Attorney General 2 December 1924. MNA 47/LIM/1/24, 100.Rennick 2003, pp. 190-202.

73 Lyons 1994, pp. 204-205. For the ambiguities of male nursing in twentieth-century South Africa, see Burns 1998.

74 Laws to Martin 14 December 1926. MNA 47/LIM/1/1/25 (a), 744; Stuart to Laws 26 August and 2 September 1926. MNA 47/LIM/1/1/36.

have “a certain proficiency” in reading, writing and arithmetic, be of good “character” and recommended by their missionaries. The three-year course was to be taught in the vernacular “supplemented by simple English”. During training, board and uniform were to be provided and in their final year students would be paid five shillings per month. The first-year curriculum would include “Ward Work, Hygiene and Elementary Nursing”; the second, anatomy and physiology, hygiene, surgical and medical nursing; and during the final year “theatre work and midwifery” were added to the curriculum. After the final examination those nurses who had achieved over seventy per cent and had a good report of conduct, would be awarded a Certificate. Certificated nurses would be entitled to a monthly salary of ten shillings per month, rising to fifteen shillings in due course. Those passing with lesser marks would become Assistant Nurses and receive a salary of between six and ten shillings per month.[75]

Livingstonia ran its most ambitious medical courses during the 1920s, largely under the instruction of Dr John Todd who believed in providing the best possible training to his students. Todd initially shared Laws’ long-term vision of developing the Overtoun Institution into a University, which would have eventually trained fully qualified and officially recognised African doctors. However, Laws’ position in the mission weakened and, along with economic difficulties, this meant that education at the Overtoun Institution was scaled down: the plans for higher medical education were shelved and the medical courses were phased out. Plans were drawn up in 1930 for the amalgamation of the Livingstonia and Bandawe medical courses after the initial year of study. Todd argued, in 1932, that the highest level of training should be given at Blantyre, while the training of dispensers could continue “on a small scale” in Livingstonia.[76] The last group of hospital assistants to graduate from Livingstonia, were trained by Todd between 1930 and 1933. They passed the Government Hospital Assistant examination in Physiology, Anatomy, Hygiene and Pharmacology and were, according to the Director of the Medical and Sanitary Services, “the best that have hitherto been examined”.[77]

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75 Laws to Rajpathak 13 October 1924. MNA 47/LIM/1/1/24, 21; Minutes of the Mission Council July 1926. MNA 47/LIM/3/18; “Livingstonia Mission Course of Training for Certificated Nurses.” MNA 47/LIM/4/2. At this time Livingstonia employed two sisters, Mary and Helen Patrick, as nurses. It is probable that the training course was designed by Helen Patrick, who worked in the DGMH. See Sinclair 2002, pp. 351-352.

76 Laws to Ashcroft 23 December 1926. NLS, MS. 7889, 103; Overtoun Institution Senatus Minutes 20 January 1930. MNA 47/LIM/32; Todd to Young 15 January 1932. MNA 47/LIM/1/5/5.

77 Director of Medical and Sanitary Services to W.P. Young 24 March 1933 and 6 November 1933. MNA 47/LIM/1/5/5. Three of these graduates passed with distinction in some of the four subjects; one, Grant Nyirenda, with distinction in all.

Motivations of "middles"?

In her study of the role of African medical auxiliaries in colonial Uganda and Belgian Congo, Lyons has analysed the motivations that led individuals to join the medical mission. Some, she argued, had internalised the values of the missionaries seeing medical practice as a noble service to their fellow countrymen. Others were attracted to the job in order to achieve prestige, personal authority and power. The attractiveness of European medical technology was also a contributing factor: access to microscopes, surgical instruments and hypodermic needles (especially after the introduction of neosalvarsan injections whose rapid effectiveness was visible) was fascinating. Furthermore, medical work was well paid: in Uganda medical work was provided the highest rate of pay available during the entire colonial period.[78]

In Nyasaland, medical work was also a comparatively well-paid career for men. Hospital orderlies were paid twenty shillings per month in 1927, while the more highly-trained hospital assistants were paid more, making them among the most highly-paid Africans in the Protectorate.[79] The salary of Yoram Nkata, an experienced and trained hospital assistant, rose from £2 10s to £3 in 1927 just before his death. Nkata's salary was comparable to that of the leading Livingstonia schoolmaster, E.B. Manda. African nurses, however, were paid much less than men, in the early 1920s – before Nurse Patrick's proposal was accepted by the Mission Council – nurses were paid just two shillings per month plus food. In 1927, it was reported that the new pay scale for the nurses would range from four to nine shillings per month, according to the period of service.[80]

As has been noted, the colonial administration and European companies offered significantly higher salaries than the mission, although within the mission service the assistants were paid relatively well. However, missionary emphasis on the control and supervision of assistants meant that the opportunities for independent work within the mission were probably less available for hospital assistants than for the theological graduates. What was perhaps more important than their salary was the fact that mission employment enabled some medical assistants to remain and work within their home area, avoid labour migration and become important and respected members of their communities. The early mission-employed medical assistants were often married church elders with established positions in society and a family to look after, all of which made migration a less attractive option. In contrast, of the younger medical students trained after the war, most pursued their careers outside the mission – which could not afford to employ them at any rate – and

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78 Lyons 1994, pp. 218-219. See also Hunt 1999.

79 Laws to Turner 2 February 1927. MNA 47/LIM/1/1/25 (a), 794. The 1931 census of male African labourers in Nyasaland showed that 11,617 labourers earned less than six shillings per month, 41,984 earned between six and twenty shillings, and 3,064 earned over twenty shillings per month. Iliffe 1984, p. 262.

80 Minutes of the Mission Council, June 1926 and July 1927. MNA 47/LIM/3/18; Overtoun Institution Senatus Minutes 3 January 1927. MNA 47/LIM/3/32.

many left the Protectorate altogether. Livingstonia-trained assistants moved to South Africa, the Rhodesias, Belgian Congo, Tanganyika and beyond during the 1920s and 1930s. Local and regional mobility was important part of the identity of African nurses and assistants in colonial and missionary medical service, as Hunt has noted.[81]

The assistants' access to European medicines could inspire suspicion as well as respect. According to Marwick, among the Chewa of Northern Rhodesia in the 1940s and 1950s, Western medicines were sometimes regarded to be superior to African medicines, but were generally understood in the same way as the local *mankhwala.* Injections were regarded to be especially powerful, because they introduced *mankhwala* into the body more effectively than the local method of rubbing medicines into incisions in the skin. The success of Western hospitals was attributed "to the power, i.e. magical power, of the drugs". However, like indigenous medicines, Western drugs could be used for evil as well as for good, and fear of the hospital was "rationalized by the assertion that Africans employed at the hospitals are in the habit of killing patients with 'medicines' selected from the formidable armoury at their disposal."[82]

Arguably African assistants, European doctors and nurses could all be regarded as possessors of ambiguous medical power, but this argument should not be overstated. The assistants dispensing medicine clearly had access to some aspects of European medical power (for example, vaccinations) but often their access to Western medicines was strictly limited. Europeans treated the more complicated cases, kept the strongest medicines to themselves and as a rule only Europeans were allowed to treat European patients. The ordinary practice of the dispensers, and especially the constant dressing of ulcers, which formed a large part of their work, was commonly considered to be a dirty and lowly job. In the case of the first UMCA dispensers, Good has argued that they were not particularly admired by their African patients.[83] Injections were rare during most of the period under review, and it is unclear at which point African assistants in Livingstonia gained access to effective anti-yaws injections. Furthermore, it should be kept in mind that becoming a Christian in itself could be seen as providing access to new powers and energies by many first-generation converts and prospective Christians..[84]

Stefano Kaunda, for one, appears to have successfully combined the roles of a healer and an evangelist in his practice in Bandawe. Such a combination can be seen as a successful internalisation of some medical missionary values as well as a crossing of social and cultural boundaries. Kaunda, a former slave and orphan, probably would not have had easy access to traditional medical authority and power. However, the status of an assistant-elder was clearly far below that of a doctor-reverend within society and, although the hospital

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81 Laws to Ashcroft 12 August 1925. NLS, MS. 7888, 106; Hunt 1999, 168-179. Stefano Kaunda, for example, had been hesitant to return to work in Kasungu as a teacher-evangelist. EUL, MacAlpine Papers, MS. 3086.2.

82 Marwick 1970, pp. 70-71.

83 Good 2004, p. 326.

84 Ncozana 2002, *passim.*; see also Chapters 8, 11, 12.

assistants were often prominent members of their congregations, the outstanding leaders of the emerging church in Livingstonia tended to be non-medical elders, preachers and reverends such as Y.Z. Mwasi, Charles Chinula, Yuriah Chirwa, Edward Boti Manda and Andrew Mkochi, among others.[85] Not all of the prospective pupils for the medical course wished to become medical assistants. Only four students were enrolled on the course in 1926, while there would have been room for eight students. Medical training was costly, and sometimes training was delayed or cancelled for economic reasons.[86]

There were particular risks and drawbacks for the "middles" if they chose to pursue a medical career. Many of them died during service, and it was often believed they had contracted a fatal disease in hospital or had been otherwise exposed to disease in the course of their medical practice. MacAlpine believed that Kaunda's fatal pneumonia was largely due to his attending a midwifery case at night, when he travelled about sixteen miles in chilling conditions. Nurse Henderson reported, in 1908, that after a hospital assistant at Kasungu was taken ill suddenly and died after a few days' unspecified illness, the missionaries were unable to find anyone to take his place. Yoram Nkata's death in 1928 was believed to be partly due to overwork at the hospital.[87] A medical student attending the hospital assistant course died in 1926 of what Laws and Burnett believed to be either an accidental overdose of medicine or suicide.[88] The deaths of medical assistants, nurses and students undoubtedly dented the reputation of mission hospitals among Africans, for if the hospital could not take care of their own, its claims to medical superiority would seem dubious.

Middles and therapy management

In Northern Malawi, as elsewhere in Sub-Saharan Africa, healers often played a crucial part in settling conflicts within society, which could result in illnesses if they were not resolved. Intermediaries of various kinds were significant in pre-colonial cultural patterns of negotiation. As senior African Christian Noah Chiporoporo advised MacAlpine in the mid-1890s (after the missionary enquired why the people did not ask anything after his sermon), a direct approach to the "one we wish to consult" was not preferred in the Tonga culture, where the intermediaries, "mutual friends", were crucial in religious as well as in medical matters.[89] In such a setting, a mission-trained medical

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85 McCracken 2000; Thompson 1995.

86 Copy of Badenoch to Laws 5 January 1926. NLS, MS. 7889, 7; Laws to Faulds 21 December 1926; Laws to Wilson 16 February 1927. MNA 47/LIM/1/1/25 (a), 749, 816.

87 EUL, MacAlpine Papers, MS. 3086.2; Henderson 18 November 1908. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1909, pp. 9-10; Martin 4 June 1928. Sinclair 2002, pp. 326-327.

88 Laws to Resident, Karonga, 4 April 1927. MNA 47/LIM/1/1/25 (a), 886.

89 EUL, MacAlpine Papers, MS. 3086.2; Young 1931. See also Long 1962. Lyons has pointed out how in Uganda in the 1950s, some chiefs preferred to have outsiders as colonial medical auxiliaries believing that such outsiders would be less likely to get involved in local feuds. Lyons 1994, pp. 220-221.

assistant or nurse experienced both the advantages and disadvantages of being an outsider, but was not as distinctly "other" as the missionaries. Although the medical assistants could be approached more easily than Western doctors, they would remain outsiders in issues connected to family therapy, for example. However, many medical "middles" at Livingstonia worked among their own societies and within a growing Christian community, where they became important figures in their dual roles as elders and assistants.

A former slave and orphan such as Stefano Kaunda had to establish his social networks from scratch in the Christian and village communities. As a medical assistant, he negotiated between mission doctors, patients and therapy managers. As a ruling elder, he became an influential figure who negotiated in cases of marriage and divorce, among other issues.[90] He was apparently also a spokesperson for the Bandawe congregation in matters of medical care. In 1906, he took a holiday away from the dispensary and walked to Kasungu, a week's journey, to meet with Prentice, his old doctor-in-charge. Kaunda and Prentice recalled the days when they worked together with Nurse McCallum, and Kaunda told Prentice that, *"if the Atonga were rich they might combine to pay a European nurse, but being poor they cannot do so"*.[91] Kaunda appears to have been appealing for a missionary nurse to be stationed at Bandawe, on behalf of the Bandawe congregation. Perhaps because of Kaunda's request, Prentice continued to champion the medical interests of Bandawe, as well as Kasungu, and repeatedly appealed for increased hospital funds for both areas. Kaunda's successor, Yoram Nkata, took six patients from Bandawe to the DGMH for treatment in 1924. He also addressed the missionary conference at the Institution and requested that a doctor be posted at Bandawe.[92]

In sharp contrast to Kaunda, the son of an established healer such as Mawelera Tembo would have had pre-existing family and social networks that could be both a powerful asset and a source of potential conflict and difficulties for a first-generation convert. Tembo seems to have managed to negotiate between the old and the new remarkably well, being well respected both in the Livingstonia Presbytery and in his local community at Njuyu. Eventually he became an adviser to the heads of the royal family, Amon and Yohane Jere, just as his father had advised M'mbelwa. In 1930, after the establishment of indirect rule, he was a "Group Headman" providing the authorities with a census of his area. Missionaries admired his strong Christianity, his brick house, and his earnest desire to give his son the best possible mission education.[93]

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90 Minutes of Presbytery of North Livingstonia 10 May 1906. NLS, Acc. 7548 D 71.

91 Prentice 5 December 1906. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1907, pp. 9-10.

92 Prentice 22 February 1907. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1907, pp. 34-35; Martin 25 September 1924. Sinclair 2002, p. 206.

93 Trotter to Mackinlay 2 December 1906. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1907, pp. 4-5; Cook 1975, p. 101. The importance of brick houses to the mission project of civilising has been pointed out by the Comaroffs (1997, pp. 274-322). Annual Report of the Provincial Commissioner for 1930, MNA S1/478/29.

Medical middles were crucial to negotiation between the doctors and the patients and therapy managers, especially when the doctors did not speak the vernacular languages of their patients. They were the first to receive and consult with the patients and their associates when they arrived at the station.[94] In this role, Livingstonia African assistants and nurses – like those African nurses trained in Lovedale in South Africa – occupied a crucial position as "culture brokers" for missionary medicine, compensating for both linguistic and cultural differences between doctor and patient. Digby and Sweet have plausibly argued that in the case of twentieth-century South African nurses, their opportunities to act informally as mediators and culture brokers, who advised patients who fluctuated between Western and African medicine, were at their greatest when nurses were working in remote clinics or dispensaries without constant European supervision.[95] In Livingstonia, Mawelera Tembo, Stefano Kaunda, Yoram Nkata and others, were sometimes left in charge of a hospital or dispensary. When working with the doctors, they would enable cross-cultural communication in addition to their medical duties. In local interpretations, the medical assistants were undoubtedly regarded as both preachers of Christianity and intermediaries of missionary medicine.[96] According to S.M. (b.1907), the assistants would ask newly-admitted patients if they were members of any church, and non-Christians would always be advised to join the church.[97] The missionaries in Malawi often believed that African patients were more willing to receive medicines from the assistants than from the white doctors.[98]

In a study of Malamulo Mission Hospital in Malawi from 1907 to 1964, based on oral testimony, S.K. Sayenda has argued that African assistants increased the extent of the control that hospitals could exert over patients by assuming the role of "semi-relatives", while the patients' actual relatives were physically removed from the hospital and only allowed to visit at given times.[99] In Livingstonia, a similar process took place first and foremost at the DGMH, but also in smaller hospitals. However, the assistants above all negotiated and interacted with the therapy managers, persuading them to leave the patient in the hospital. If the negotiations between assistants and guardians were successful, the permission of the patient was not necessarily required.[100] On the other hand, even close mission associates frequently refused to take their

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94 See, for example, *Other Lands* July 1926, pp. 125-126; Oral testimony, P.L.M. and D.C. M., 9 July 2004. According to P.L.M., *"it was the duty of the hospital assistants to explain the patients problem to the mission doctor, because the local people (most of them) could hardly communicate in English. The hospital assistants were relaying the symptoms and the doctor, having been trained, knew exactly the kind of medication required."*

95 For Lovedale-trained nurses in South Africa, see Digby and Sweet 2002, p. 123-127 and *passim.*

96 Oral testimony, D.M.M., 9 July 2004.

97 Oral testimony, S.M., 12 July 2004. However, this informant, whose earliest experiences as a hospital inpatient were from Ekwendeni in the early 1930s, recalled that at the hospital, there were no specific prayers, only the distribution of medicine.

98 Rennick 2003, p. 203.

99 Sayenda 1989.

100 Oral testimony, E.K. M., 8 July 2004. Interview with Rev. S. Bota, June 2004.

relatives to hospital. The Bandawe station "kapitao" (overseer of station workers) refused to take her daughter to the hospital or allow assistant Nkata to treat her in December 1924. The girl's father was reportedly afraid of the "evil spirits which inhabit the hospital".[101]

Language, confidence and communication

Successful co-operation between medical "middles", therapy managers and patients, made it possible to establish and maintain an extensive and successful medical practice even under circumstances where the doctor did not understand his patients and vice versa. In 1907, two assistants who were enrolled on the medical course at the Institution helped Robertson to begin his practice immediately after his arrival. Robertson believed that he "*gradually picked up phrases* [of vernacular]*, but on the accurate use of these one was not inclined to base anything vital.*" After three months at the Institution, Robertson was moved to Bandawe, where he admitted that his ignorance of chiTonga limited his work considerably, even though his dispensary was busy from the outset. Robertson believed that people's confidence in their doctor was crucial to his practice, and saw the necessity of learning the vernacular language in order to gain this confidence. A month later, he was happy to report that people were visiting the dispensary and agreeing to operations far more willingly than he thought would have been the case with a new doctor whose understanding of the vernacular was still *"dim"*.[102]

"Mankhwala" was a common request for medicine that the missionaries could easily understand. Patients' complaints were often understood only vaguely, such as the perplexing complaint of "nyamakazi" (often translated as "rheumatism") sometimes understood as a comprehensive complaint of pain with no effective cure.[103] Nurse Henderson described, in 1908, how she was asked for medicines in villages across the Kasungu district: *"The women are all very much delighted when I produce my medicine box; then nothing can be heard but shouts of "Chifua," which means that they have a bad chest."*[104]

The missionary doctors constantly stressed, that time and patience were required in order to gain people's confidence and build up a busy medical practice. This was certainly the case at new stations such as Kasungu in 1904. The most common languages in Kasungu were chiChewa and chiWiza rather than chiTonga, which Prentice had studied in Bandawe.[105] However, in Bandawe at least, where missionary doctors had come and gone since 1881, the

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101 Martin 29 December 1924. Sinclair 2002, p. 224.

102 Robertson 2 January and 13 February 1907. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1907, pp. 19-20, 32.

103 *Annual Report for 1902*, pp. 38-40; Lwanda 2002, p. 58.

104 Henderson 18 November 1908. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1909, pp. 9-10. "Bad chest" in the early 1900s could refer, for example, to pneumonia, influenza, bronchitis or tuberculosis, which was spreading in the region.

105 Prentice 3 February 1904; 13 July 1904. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee 1904.

people seemed ready to consult new doctors soon after their arrival. Between 1899 and 1911, Kaunda's presence as a medical assistant brought continuity to the Bandawe dispensary and hospital. Through him, it was easy to approach new doctors. Soon after Dr Brown arrived in Bandawe in 1906, MacAlpine observed that his dispensary was "daily besieged by patients".[106] It was Kaunda – perhaps assisted by the elderly African nurse mentioned by Fraser – who negotiated Robertson's early practice. Kaunda's successful work as a medical "middle", together with Robertson's skill as a surgeon, the success of cataract operations, and Robertson's efforts to study the vernacular could, arguably, explain the boom in surgical practice at Bandawe between 1908 and 1910.

While medical practice and therapeutic relationships could be established even whilst the doctor was ignorant of the vernacular, preaching to an uncomprehending audience was futile. Ordained medical missionaries had to at least try to learn local languages, but often it is difficult if not impossible to assess how well the missionaries actually spoke and understood these languages.[107]

9.3 Encounters in fixed spaces of healing

Hospital space

One of the main difficulties for the physician, as noted by Prentice during his first term of service at Bandawe, was the disorderly nature of medical encounters in the mission dispensary:

> ...there was not a room on the station into which patients could be taken for treatment. The old manse was still standing and in the end rooms of it, the medicines were kept. The patients assembled daily at the doors, bawled out their complaints, and received medicine. It would perhaps be wrong to say "were treated"; for the examination necessary to get at the root of the disease was impossible under the circumstances…There was not a table in the dispensary on which to lay a patient for an overhaul…[108]

A major problem for the doctor was the ordering of space. The "bawling" patients, who could not be properly examined individually, formed a chaotic or even (seemingly) threatening group. Within a year, Prentice had a new cottage dispensary with a waiting room and a consulting room.[109] This enabled him to

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106 MacAlpine 23 March 1906. NLS, Acc. 7548 D 71.

107 Missionary language examinations were set by senior missionaries, not by Africans. In the early 1908, Dr Turner tried to read to the Institution in-patients on Sabbath afternoons, but felt that his lack of language limited his explanation. Turner 10 April 1908; Minutes of the Mission Council September 1908. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1908, pp. 90-91, 146.

108 *Report on Foreign Missions for 1899*, pp. 98-99.

109 Prentice to Smith 24 June 1895. NLS, MS. 7878, 200. For the socialising in southern African dispensary, see Landau 1996.

consult and examine each patient individually and at least in theory separate them from the group of other patients and their associates.

This reordering of space at the mission dispensaries and later hospitals enabled the separation of a patient from his friends, relatives and "well-wishers", including the therapy managers. Although the idea and reality of dealing with an important family instead of an individual patient was not entirely alien to late Victorian and Edwardian medical practitioners, they were trained to deal with individual patients in the privacy of a consulting-room rather than large groups.[110] The power and authority of the doctor largely depended on an intimate, closed relationship with the patient, who would be examined on the table and interviewed privately by the doctor. As Brown and Smith have noted, the British doctors of the late nineteenth-century expected deference from their patients especially from lower class patients. Little sympathy should be shown to them, and a "short and decisive" manner was preferred.[111] The patient was to obey and believe the doctor unquestioningly, show appropriate gratitude and answer all questions put to him.

In contrast, in the Malawi region, the role of therapy managers and guardians who were often close older relatives of the patient was crucial to the negotiation between the healer and the patient. Fathers – in patrilineal societies such as the Ngoni – and the mother's oldest brothers – in matrilineal societies such as the Chewa – were the male heads of household and had important roles as guardians and therapy managers. Mothers, grandparents, husbands, wives, and siblings could also be leading therapy managers. In practice, therapy management within the family could be a complicated affair and several people could be involved in the negotiation. The importance of the Ngoni chief's head wife, as well as mothers and grandmothers in general, has been noted above. It was possible that the missionaries never met the actual leading therapy manager at all. Although old women were often believed to be leading therapy managers, the missionaries did not usually describe these women approaching the mission directly.

Often it was one or more members of the therapy management group, not the patient, who would at first approach a healer. Missionary doctors frequently noted that a husband, parent or friend had come to ask for medicine or treatment for the patient. Sometimes the patients were dragged to the hospital

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[110] This was in marked contrast to the situation in late eighteenth- and early nineteenth-century Britain, where, as Rosenberg has noted, "middle-class practice took place in the patient's home and necessarily involved family members, both as possible causes of stress and as potential factors in the recovery process." Rosenberg 1989, p. 188.

[111] Brown 2004, p. 339, Smith 1979, pp. 264-265. However, it should be noted that such attitudes were not typical to all doctors. If ideas of class and rank were crucial to many Scottish, as well as English and Welsh, practitioners, it should be noted that many Scottish-educated doctors themselves came from working or lower middle classes. Furthermore, the Christian missionary role may have sometimes checked racial attitudes and forced the doctors to seek a lasting communicative relationship with the patient based not merely upon demands for obedience but rather persuading the patient to continue contacts with the mission.

or dispensary unwillingly.[112] The patient would have to submit to the will of the therapy managers, and the healer was often supposed to advise the therapy management group about the nature of the illness and the suggested course of treatment before the patient was informed. Sometimes the healer would not give the patient any information about his diagnosis or the proposed therapy, leaving that responsibility in the hands of the therapy managers. This was a potential source of cultural conflict within the mission hospital.[113]

After he was posted to Kasungu, Prentice followed a building policy similar to that which he had introduced at Bandawe. However, the realities of this pioneer station forced the doctor to adjust and improvise with the buildings available. He wrote, in 1904, that under the circumstances he had to use what was meant to be a waiting room as in-patient accommodation for a man awaiting an operation. Prentice noted that by this time, over three years since his arrival, he was increasingly receiving patients from some distance away, who had to be accommodated somehow. Before he could set up a few huts for these patients, the waiting room had to be used as an in-patient ward.[114]

The missionary hospitals in Livingstonia in the early twentieth century developed in the context of continuing exchange between the missionaries, medical "middles", patients and the therapy managers. In Bandawe in 1907, for example, Robertson noted the need to also accommodate the patients' friends and relatives who fed the in-patients and socialised with them, making an important contribution to the nursing of the patients.[115] After the establishment of the Bandawe hospital the following year, Robertson welcomed the therapy managers:

> We make the rule that patients should bring their friends to feed and look after them. This brings rather many people about the place and crowds up the rooms, as family circles at times come, but it relieves us of work and responsibility which could not be overtaken and borne as nursing arrangements are here at present.[116]

In the history of the Bandawe hospital, it should be kept in mind that Robertson worked together with Kaunda (and unnamed Christian nurse) who linked the hospital to the Christian community in Bandawe, and who ran the practical arrangements. They probably helped Robertson realise the need to accommodate local therapy management practices within the hospital scheme. Thus, the therapy management groups could be turned from a potential problem into an asset. However, from the missionary point of view, "order" was essential in a hospital. At Bandawe, MacAlpine stressed how orderly the

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112 For example, see Ballantyne's description of a woman taken to the Institution by her complaining husband. Ballantyne 3 February 1907. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1907, pp. 28-29; *Annual Report for 1902,* pp. 38-40.

113 Interviews with Dr Alister Munthali and Rev. Steven Bota, June 2004.

114 Prentice 4 April 1904. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee 1904, pp. 82-85.

115 Robertson 29 April 1907. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1907, pp. 65-66.

116 Robertson 8 August and 7 September 1908. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1908, pp. 130-132.

new hospital was, with “no loiterers on the station path”. The outpatients entered the dispensary room from the back verandah of the hospital and after receiving medicine, left from the front. Convalescent patients were located at the back verandah so they were out of sight from the main mission station. The patients’ relatives cooked food in an iron-roofed shelter at the back of the hospital.[117]

The erection of separate huts for distant patients and their relatives was often a necessity. Like Robertson, Elmslie at Ekwendeni realised that this was also an economic and practical solution for the first missionary hospitals. Relatives and friends could feed, nurse and accompany the patient into a hut, which was comfortable for the patient and saved the station the expense of nursing the patient. This was the arrangement at the Ekwendeni hospital in 1907. Thus, financial constraints, and the lack of a full-time European nurse, contributed to a situation where missionaries and therapy management groups could co-operate to ensure the well-being of the patient in relatively familiar conditions. Such missionary hospitals were distinctly “African” in contrast to the European ideal of a clinic as an ordered space organised for the purposes of medical “gaze”, focusing on isolated individuals. Furthermore, in the absence of European medical staff, the African medical middles took on an increasingly independent role in medical work at the outstations. In Karonga in 1919, for instance, Fred Nyirenda was in sole charge of in-patients. A couple of huts were erected for the patients, many of whom were reportedly suffering from ankylostomes, and Laws noted with approval Nyirenda’s ability to treat these cases, many of whom could not undertake the arduous journey up to the DGMH.[118]

However, the Institution central hospital slowly began to develop along Western lines, with more restrictions and limitations imposed on the mobility of patients and transactions between patients and therapy management groups. Elmslie preferred to send the more serious cases from Ekwendeni to the Institution and expected that therapy managers would take responsibility for the transportation of patients. He admitted that there were “friendless people” who could have no one to carry them to Khondowe, but in such cases the missionaries would organise their transportation to the plateau. Furthermore, Elmslie wanted to limit the number of medical visits made to patients’ homes, instead preferring to send patients to the Institution at their own expense.[119] Thus, his role at Ekwendeni increasingly became that of a refereeing agent for the Institution hospital.

When the missionaries started feeding the patients according to their ideas of a suitable “invalid diet”, they could encounter new difficulties. Agnes Fraser complained in 1902 that, in Ngoniland, drinking fresh milk or milk beaten up with egg as well as eating fowls was disdained by the general population. The

117 MacAlpine to Binnie n.d. September 1908. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1908, pp. 146-148.

118 Laws to Resident, Karonga, 9 September 1919. MNA 47/LIM/1/1/19, 231. Cf. Foucault 1976.

119 Elmslie 18 January 1908. NLS, Acc. 7548 D 71.

men only drank curdled milk and women or chiefs did not drink milk at all. Fraser was forced to disguise her cooking for the in-patients as *"the food of our country"*. In one case when she ordered a recovering teacher to eat *bara* – gruel which was considered to be infant food – the patient's wife deserted him, claiming that he "wasn't a man", and only returned after he resumed eating *nsima.*[120]

At the DGMH, the patients' relatives were not allowed to stay in the wards, and had to find their own accommodation in the local vicinity. The relatives were only allowed to visit and bring food to in-patients. In 1916 the hospital charged two shillings and a sixpence per month for patients' food and "upkeep". The limitations on the patients' movement and their relatives' visits caused resentment and made the hospital unpopular.[121] The more the hospital provided for the patients, the less need there was to co-operate with or accommodate African therapy management within the working practices of the hospital. The ordering and organising of hospital and dispensary space can be likened to the Comaroffs' notion of houses as sites of contests and complex encounters between Europeans and Africans during the colonial period.[122] The practical and material necessities of the pioneer hospitals forced the missionary doctors to make concessions to the therapy managers of the in-patients: the hospital welcomed those relatives who took responsibility for the patients' upkeep. However, with the establishment of larger hospitals, in particularly the DGMH in 1911, the mission hospital in Livingstonia changed, becoming a more complex, hierarchical space where in-patients would increasingly be separated from their therapy management groups. Situated as they were between patients, practitioners and therapy managers, the African medical "middles" became increasingly important.

Generally, the people of the Khondowe plateau regarded the DGMH as *chipatala cha chizungu* – "the hospital of the white people" – [123] an alien place with strange therapies. For most of the Africans in the vast Livingstonia sphere, the hospital was simply too far away and too difficult to reach to be a viable therapeutic option.[124] Nevertheless, its remoteness could also enhance its reputation as a place of extraordinary healing, following the cultural pattern of "mystical geography" where distant places are attributed with extraordinary powers and energies.[125]

Everyday practice

In 1904, James Chisholm described typical daily practice in Mwenzo hospital:

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120 *Annual Report for 1902*, pp. 38-40.

121 Minutes of Mission Council 18 October 1916. MNA 47/LIM/3/17; Laws to Acting Chief Secretary, Zomba, 24 January 1919. MNA 47/LIM/1/1/18.

122 Comaroff and Comaroff 1992, p. 273.

123 Oral testimony, S.M., 11 July 2004.

124 Minutes of the Mission Council 18 October 1916. MNA 47/LIM/3/17.

125 Ranger 1975a, p. 9.

> perhaps the majority of [patients] have not been attended to by the missionary personally. For example, there may be, say, twenty-five cases in the waiting-room at the dispensary hour. Each of these is examined by the doctor – five may be found to have malarial fever, five simple abdominal derangements, five coughs and colds, five the common native ulcer; these are all separated into batches, and the native assistant knows how to attend to them quite satisfactorily from stock bottles prepared for him. The remaining five may have to be attended to personally – an abscess opened, a tooth drawn, a cut stitched, a special bottle of medicine dispensed, or a time for an operation arranged. These figures are not meant to be proportionate, but to show how a large number of patients may be attended to without taking up much of the missionary's time.[126]

When prescribing medicines for home use, the doctors often found it difficult to explain when and how much medicine the patient should take, and the lack of spoons prevented exact measurement for many. Agnes Fraser's preferred method in 1902 was to say *"Drink a very little in the morning, at noon, and in the evening; finish it in so many days."* She was careful to dispense only small quantities of medicine at a time in order to avoid potentially dangerous overdoses, and threatened "serious consequences" if anyone other than the patient was given the medicine she had provided. Medicines were dispensed in penny ink, lime juice and Eau de Cologne bottles as well as "jam tins",[127] which probably often blurred the lines between medicine and European items in local perceptions. Missionaries rarely mentioned cases of overdose, but they certainly occurred in the pioneer period: in the 1880s William Scott had prescribed large doses of mercury to a man who gave it all to his wife, whose teeth Scott later described as "hanging out" due to the mercury poisoning. At the Institution, in 1904,, all medicine was drunk on the premises under supervision, "to save life".[128]

In a letter to Prentice, Laws described at some length the medical practice at the DGMH, where he was the only physician in 1920. The hospital was busy with a number of serious cases: Laws had amputated a "smashed leg", and the patient was "well" and ready to be sent home to Bandawe. Another amputation was performed on a woman with *"breasts so ulcerated that immediate amp. of one seemed the way of safety to life."* This patient was recovering as well, and Laws' prognosis was good. A third patient, with a broken clavicle, had however *"bolted after three days"*. Two children had died, *"through terrible ulcers – come too late."* There were, at the time of writing, four venereal patients – the others having left. All of the hospital beds were full, and Laws was awaiting the arrival of Nurse Ferguson. W.P. Livingstone provides another account of hospital routines at this time. In the morning, Laws would say prayers with assistant Yoram Nkata and the three African nurses before holding a short service for the outpatients. The doctor would then undertake a short round of the wards. Mrs Laws would administer chloroform during operations. Nkata was in charge of much of the hospital, entirely so during the night and would

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126 Chisholm 30 June 1904. NLS, Acc. 7548 D 70, Letters to the Sub-Committee 1904, pp. 106-107.

127 *Annual Report for 1902*, pp. 38-40.

128 Scott 1985, p. 54; Fiddes, n.d. NLS, Acc. 7548 D 71: Letters to the Sub-Committee 1905, pp. 38-39.

only alert Laws in an emergency. After the resumption of medical courses in the 1920s, the medical staff consisted of the doctor, European and African nurses, the medical assistant and the students. Mamie Martin described the DGMH in 1922 as “sadly lacking” when compared with hospitals in Britain, but “a marvel” compared with other hospitals in Livingstonia.[129]

The hospitals could only provide pain relief and feed many chronic patients. In September 1920, Laws discharged a long-term patient, Simon, a mission teacher, from Ekwendeni. He had been in service during the war, and had been hit by a lorry. Laws feared that Simon was suffering from tuberculosis when he began to spit blood. He was hospitalised and morphia had stopped the patient spitting blood, but he had become severely emaciated. He was fed cod liver oil and milk and as he had gained some weight, Laws sent him home. Laws noted that if Simon was not required to do teaching, he should *“spend most of his time in the open air with the cow’s teat in his mouth all day”*, in addition to any treatment provided by Elmslie.[130]

Patient images and stereotypes

Prentice described patients of the Bandawe dispensary in a letter in 1899:

> one recognises the faces of many old medicine eaters – people who seem to conjure up some ailment every time they happen to see the doctor at the dispensary. But there are also strange faces, some of which portray a certain amount of fear as the sufferer gives the history of the complaint. One was that of a woman who suffered from a condition she knew I had cured in others. Another was a patient from Karonga, who wished to combine a visit to friends in the district with a course of treatment.[131]

This passage contains two stereotypical missionary images of the African patients: experienced local “medicine eaters” and wary newcomers who had travelled some distance. In 1904, Jessie Fiddes (a nurse-teacher) was left in charge of the Institution dispensary in Laws’ absence. She wrote of her dispensary practice in detail:

> One man came in complaining of pain in his ear. On examination I could not see anything apparently abnormal, and so come to the conclusion that he must be suffering from neuralgia; at any rate, a tonic would do him no harm...I handed him 3 grs. of quinine solution, and looking up a few seconds afterwards to take the glass from him...he was pouring the bitter tonic down his ear...
> ...I noticed that, if the patients had any local pain, they invariably wanted something to rub on, and could not see the wisdom of taking ”munkwala” (medicine) internally for such…Again I was surprised at so many coming, asking to have good teeth extracted. If the tooth was good I would never attempt to extract, but gave some quinine solution, the pancea for almost everything in a fever country. Then I had to

129 Laws to Prentice 23 June 1920. MNA 47/LIM/1/1/19, 718; Livingstone 1921, pp. 364-365; Martin 26-28 October 1922. Sinclair 2002, p. 98.

130 Laws to Elmslie 29 September 1920. MNA 47/LIM/1/1/19, 848.

131 Prentice to Smith 21 November 1899. NLS, Acc. 7548 D 69.

> stand patiently and watch the patient lay the solution, drop by drop, round the affected tooth, until all had trickled down his throat.[132]

The missionary narratives frequently represented African patients as ignorant, untrustworthy or comical, turning arm slings into loincloths, or appropriating small medicine bottles for holding snuff. However, some of these ethnocentric stories, such as that of the patient pouring tonic in his ear (which were intended mainly for the amusement of the readers and to highlight the difficulties of missionary practice) provide further insights into some of the cultural conflicts and misunderstandings that took place in the mission dispensary or hospital. Fiddes' narrative suggests that African patients were frequently looking for medicines to be applied externally rather than internally, and particularly in cases of "local pains" patients seemed to be disappointed with what the missionary dispensary could offer. Swallowed "bitter tonics" were regarded to be inferior to *mankhwala* rubbed directly into incisions.[133]

Another missionary stereotype represented the African patients as "lazy". The laziness of "natives" was a salient feature of much European colonial discourse about the colonized "others" from the Philippines to Central Africa. For Laws, in the Scottish Presbyterian tradition, laziness was one of the worst sins and was the antithesis of his work ethic, which aimed to establish the Kingdom of God in Africa. Laziness was immoral and could lead to the collapse of both physical and moral health. Representations of "lazy patients" could be interpreted in various ways, however. Consider this narrative of Nurse Ballantyne in 1907, which was titled *"A woman blind and lazy"*:

> The other day we heard loud talking outside the dispensary, and, on looking out, saw a man dragging his wife (almost blind) along. She was too lazy to come and have her eyes seen to, and now she is likely to lose the sight of one or both. The poor man, rather smart, with this drag on him, had a great tale of woe about her disobedience, and always finishes up with, "No mahara (sense) in this woman". [134]

Disobedience towards the missionaries or the therapy managers could be condemned as laziness by both groups. As has been pointed out, unwillingness or slowness to obey could be a form of resistance against the coercion of both colonial and indigenous authorities. The moralisation of this as laziness was a common rhetorical strategy. As Alatas and Said have pointed out, one purpose of the colonial discourse of "the lazy native" was to keep the subjects it created subordinate and industrious.[135]

While the doctors and nurses had their own ideas, images and stereotypes of African patients, they were also scrutinised, commented upon, and named by

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132 Fiddes, n.d. NLS, Acc. 7548 D 71: Letters to the Sub-Committee 1905, pp. 38-39. Fiddes' medical source books were her "Glasgow prescription book" together with Manson's *Tropical Diseases*.

133 *Annual Reports for 1901,* p. 26; *1902,* p. 38. Cf. Marwick 1970, pp. 70-71.

134 Ballantyne 3 February 1907. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1907, pp. 28-29.

135 On the myth of the "lazy native" see Alatas 1977; Said 1994, pp. 296-297.

Africans.[136] Missionaries, like other Europeans, were typically given several nicknames in the vernacular, which they would be largely unaware of, particularly the less flattering ones. According to one informant, *"In most cases, if we had doctors who carried their duties well…they were given local names in appreciation"*. One physician from the later colonial period was apparently likened to a bee in the description of him as "stinging".[137]

9.4 Patient experiences

Pupils and workers

Pupils, apprentices and workers formed the core of the patients who attended the Institution hospital. During the early phase of intensive building, the Institution employed a large number of temporary workers on the plateau, most of them were male and many came from uNgoni. At the turn of the century, the Institution patients were overwhelmingly male.[138] In 1903, Laws reported the death of a Ngoni worker who had suffered first from dysentery and later, pneumonia. He had recovered in the hospital, but subsequently died of a fever. Another Ngoni who had been working on the construction of the road died of pleurisy in August and a third man died of dysentery in November. Laws noted, in 1904, that with the decrease of migrant labour across the plateau, the number of dispensary patients was decreasing. As Rennick has noted, the mission as employer acted as a "refereeing agent" forwarding patients to the mission medical facilities.[139] This was especially significant at the Institution, where the migrant workers were removed from their local therapeutic resources and suffered from ailments connected to the cold weather, as well as industrial accidents. With the introduction of the colonial economy, new types of accidents were increasingly being treated at the Institution. With monthly hospital in-patient fees of 2s 6d in 1916, only the wealthiest Africans or those in colonial or mission employment could afford a long-term stay in hospital. In 1926, when Laws was defending his vision of higher medical education at Livingstonia against the argument that Blantyre would be better located and equipped for advanced medical training, he admitted that *"More patients are probably been treated in the Blantyre Mission Hospital...because patients are better able to pay there than here"*. Laws argued that

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136 In 1926, Laws stated that *"the actions, words and even the looks of the Europeans...are freely criticised and appraised with extraordinary accuracy."* MNA 47/LIM/4/2.

137 Oral testimony, E.K.M., 8 July 2004.

138 In 1900, the Institution dispensary recorded 5,703 cases, of which 3,690 were male, 1,293 female and 820 children. *Annual Report for 1900*, p. 7. Most male attendances (2,778) were surgical cases.

139 Laws to Candy 4 May, 18 August and 21 November 1903. MNA 47/LIM/1/1/5, 376, 411, 476; Rennick 2003, p. 231.

many cases who would be treated as in-patients in Blantyre, could only afford outpatient treatment at the DGMH.[140]

While the Overtoun Institution quickly established its reputation as a European sanatorium, as noted previously, it was not considered to be a health resort by African pupils, apprentices, or workers. During the construction phase of the 1890s and early 1900s, the accommodation of the pupils was deemed to be very unsatisfactory by Elmslie. During the cold season in 1899–1900, there were several deaths at the Institution, and widespread unease. Elmslie believed that deaths were caused by *"fever with peculiar head symptoms (endemic to the Hara plain)"*. Illness deterred Africans from seeking employment on the plateau, and about fifty pupils did not return for the new session.[141] Elmslie reported that because of the unhealthy condition of the houses, which caused pneumonia and "bad fever", the pupils and apprentices *"do not take kindly to this place, and they are found of going home with a bad report of it"* and would often refuse to return. [142] After twenty years at Khondowe, Laws believed that the Ngonde particularly suffered when they had to stay in the hills.[143]

Accommodation, water supply and sanitation were major problems at the Institution, and the early years were marked by the illness and death of some pupils. There was a panic among the students when three pupils died, two of them from Mwenzo, in 1902. Laws wrote:

> An epidemic of influenza was followed by lung affections, and, in the three fatal cases, cardiac failure as the most marked symptom of obscure pneumonia results after a brief illness…The two lads belonged to Mwenzo, and the rest of the pupils from that district went off in a body, taking with them a convalescent companion, who, but for Dr Innes' care at Karonga, would have probably lost his life. All the pupils got a change for a few days to the lake, and returned with fresh vigour and spirit for work again.[144]

One of the casualties was a pupil named Robert who had assisted in the dispensary and taken up night duty in the hospital. It was clear that the Mwenzo students had lost their faith in the healing power of mission medicine. The missionaries were not able to prevent them from leaving even when one of them was convalescing. They formed a therapy management group for their ill companion, accepted Innes' help en route in Karonga, but were determined to take the patient and go home. Nine pupils from Mwenzo contracted fever in Laws' absence during 1905, and missionaries feared that this would result in a panic similar that of 1902,[145] but it appears no one fled from the Institution this time.

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140 Minutes of the Mission Council 18 October 1916. MNA 47/LIM/3/17; Laws to Ashcroft 23 December 1926. NLS, MS. 7889, 103; Laws 1934, pp. 122-123.

141 *Livingstonia Mission Report for 1899-1900,* p. 4.

142 Elmslie to Smith 14 December 1899. NLS, Acc. 7548 D 69.

143 Laws to Resident, Karonga, 4 November 1914. MNA 47/LIM/1/1/16, 96.

144 Laws 29 September 1902. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee, 1902, p. 92 A-B.

145 Fleming 18 August 1902. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee, 1902, p. 85; Laws 22 December 1905. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1906, pp. 34-36.

The boarders at the Institution were under constant medical and general missionary supervision. In 1906, the Institution figures show 216 residents and 123 apprentices. In 1910, there were 242 resident pupils.[146] Bruce Fetter has calculated the mortality rates of the male students at Livingstonia between 1895 and 1929 on the basis of the Institution Roll-Books, as well as the approximate death rate of the former pupils after they left the Institution. During this time, 23 of the 1,224 enrolled students died while at the Institution. Fetter points out that for the first ten years of the Institution's history, mortality figures among its pupils were actually higher than for school leavers. Eleven pupils died at the Institution between 1896 and 1902, more than during any other comparable period. However, after about 1906 the situation was reversed, and Fetter's aggregate mortality statistics indicate that between 1906 and 1929 the Institution became one of the healthiest "colonial microenvironments" open to the young Malawian men, and was clearly healthier than the microenvironments of migrant labour.[147]

The living conditions of pupils and apprentices at the Institution gradually improved. Fetter has emphasised the importance of the piped water supply installed in 1904, which improved health with regard to water-borne diseases. However, a number of deaths at the early Institution were not connected to dysentery or other water-borne diseases, but were, according to missionary doctors, caused by chest ailments and respiratory illnesses including bronchitis, pneumonia and influenza and the more obscure "fever with peculiar head symptoms". Missionaries had no effective drugs to treat these conditions, but emphasised the importance of improvements in housing, and heating. By 1919, the four Institution dormitories were heated by "khangs", a floor heating system which originated in Asia.[148]

In general, the Africans condemned the Institution because of its coldness. The reputation of the Institution as a cold and unhealthy place was not instantly improved with the establishment of the DGMH. Its wards were designed to be "swept by the fresh winds of the Lake", and many patients suspected they would die of cold there.[149]. Although the station was regarded as a health resort by Europeans, the African residents experienced it as a dangerous and deadly environment during the first decade of the Overtoun Institution.. It is possible that among those communities who heard about the illnesses and deaths of their children at the Institution, its unhealthy reputation would have lingered long after the actual conditions there had improved.

Pupils regularly attended the Institution dispensary and probably became more familiar with Western medicine than any other African group in Northern Malawi during the early 1900s. Ballantyne wrote in 1907 that:

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146 Rennick 2003, p. 328-331.

147 Fetter 1989.

148 *Livingstonia Mission Report for 1899-1900,* p. 4; Laws to Acting Chief Secretary, Zomba, 24 January 1919. MNA 47/LIM/1/1/18, 32; Fetter 1989.

149 Livingstone 1921, pp. 340-341.

> The school boys come before 9 A.M. if they need medicine, and quite a number are just like the boys at home, very anxious to play truant for a day. Some will come dragging along as if every step would be their last, and tell you they have no power and cannot learn. You cannot shame them out of it by false sympathy, but if you laugh...they will often rise to the occasion and, after a dose of strengthening medicine, run off to school without any more fuss…[150]

Through such encounters, it was possible for the missionary nurses to see the African pupils as being "just like boys at home".

Distant patients

After the emergence of the DGMH, the Institution became a centre of Western medicine in the Northern Malawi region, and Europeans acted as central refereeing agents for it. Missionaries, administration officials, settlers and traders all sent their workers to the Institution to be treated. These patients were sent to a remote location and were left without their own therapy management group in an strange hospital – an experience that must have often been alienating and frightening. In 1913, Laws described one patient's final hours to the European who had sent the patient to the hospital from the Henga Valley:

> During the night we had a very bad thunderstorm and this & the noise on the iron roof seems to have annoyed him & he would get out of bed & put his mat on the...he then got a little delirious & seemed to think his goods...were being stolen. He died at 5.45 am. Last night there was every reason to expect recovery, unless pneumonia supervened. I have found heart failure in these cases taking place without the usual symptoms...[151]

Iron beds, the cold and strict demands for "spotless cleanliness" were all trying experiences for the patients, many of whom preferred to sleep on the hospital floor. As Good has pointed out, the European practice of in-patients lying down all the day with the ward windows opened for ventilation, conflicted with the African practice of leaving the mats or beds to go outside for fresh air.[152] For many, Western treatments and examination procedures may have felt strange and disturbing.[153] Many patients fled or left the hospital clearly against doctors' orders. Body-cutting continued to be viewed with suspicion and stories of cannibalism and sorcery circulated. In some cases, people whose tumours had

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150 Ballantyne 3 February 1907. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1907, pp. 28-29.

151 Laws to Tuckett 12 December 1913. MNA 47/LIM/1/1/14.

152 Livingstone 1921, pp. 341-342; Good 2004, p. 297. Good also points out that in the early UMCA hospitals, many patients feared cannibalistic witches who would attack the patients at night through open windows.

153 In 1907, the Resident had sent a woman who had been raped and assaulted to the Institution for treatment.. Laws wrote that because of the patients' nervousness, the examination of her injured throat had not been possible. Laws to District Resident, Karonga, 27 April 1907. "Report of the case of G.N." MNA 47/LIM/1/1/9, 247-250.

been removed kept them so that they would not be used as an ingredient in European medicines.[154]

Oral tradition in the villages surrounding Livingstonia reinforces the view that the European hospital was initially viewed with suspicion and fear and was only gradually accepted as part of the pluralistic medical culture. A descendant of Mwabanga – the local religious leader at Manchewe, who welcomed Laws in the 1890s – when interviewed stated that: *"People in general were afraid since this was a new development. But later on, they gradually got used. They used to visit the new hospitals, while at the same time continuing to visit the traditional healers, also for medical help."*[155] Initially, for the majority of the population, the missionaries were clearly secondary practitioners to local healers.[156]

Transporting patients up to the Institution was an arduous task, and it could take a patient days to reach the hospital, having often been carried there on improvised stretchers. Reverends, elders and other Christian leaders were frequently involved in sending patients to the missionaries.[157] The Christian elite in Northern Malawi, together with former pupils, apprentices and workers who had positive views or experiences of the missionary dispensary and hospital, became African "refereeing agents" or therapy managers when they sent their relatives or neighbours from villages to the hospital.

Laws reported to Chisholm in October 1916, that a man in his service had been mauled by a crocodile in Vua. The patient was carried to Hara, and then by another set of men to Chitimba. Having received a telephone call from Chitambo informing him about the accident, Laws sent a third group of carriers to bring the patient up to the hospital. This patient, who had been bitten on his legs, back and hand, and who had wrestled himself out of crocodile's mouth, was reportedly doing well.[158] He was hospitalised for a long period, however. In January, Laws reported that the patient was steadily improving. The patient was anxious to return home to Mwenzo, but Laws believed that he was not yet able to make the long journey home.[159] Sending home patients who still needed assistance to move, especially amputation cases, was often a difficult process. Delays could lead to convalescent patients being left stranded at the Institution for a lengthy period of time. Such patients were the most promising for the missionaries' conversion and educational purposes. In 1904 Laws reported that a boy from Ngoniland who had his arm amputated at the Institution, learned to read the gospel in the vernacular while recovering in the hospital.[160]

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154 Laws to Prentice 23 June 1920. MNA 47/LIM/1/1/19, 718; *Annual Report for 1902,* pp. 38-40; *Annual Report for 1912,* p. 51.

155 Oral testimony, S. M., 11 July 2004.

156 Oral testimony, D.C.M., 12 July 2004. One well-known healer mentioned was Chionera Msiska.

157 Oral testimony, L.H.T., 6 July 2004.

158 Laws to Chisholm 31 October 1916. MNA 47/LIM/1/1/17, 644.

159 Laws to Chisholm 26 December 1916, 3 January 1917, 10 January 1917. MNA 47/LIM/1/1/17, 735, 755, 763.

160 *Annual Report for 1904,* pp. 24-25. The boy had been taught at the mission school previously, and knew the alphabet.

For the lonely in-patients, not only African assistants and nurses, but also other in-patients could become important helpers and advisors in alien circumstances. The patients who had successfully undergone treatment could encourage others to submit to an operation, but not always successfully. Laws described in his memoirs how one patient whose arm was badly mauled by a leopard refused an amputation, asking, "How can I hoe my garden with one arm?" According to Laws, *"Another patient urged him to look at his companion, alive after his arm had been amputated. The latter also urged the man to accept amputation..."* The man still refused, and died a day or two afterwards. Laws was, however, gratified to note how earnestly the other patients had advised the man to consent to the operation. The second patient's arm had been shattered in a cotton ginnery near Karonga, where his friends had wanted to take him for treatment. This man had, however, insisted on travelling the longer journey to the Institution hospital where he consented to the amputation of his arm.[161] It is probable that this patient had some previous connection to Livingstonia; his desire to seek Laws' surgery suggests that he was already aware of the mission hospital's potential.

Dying

It could be argued that from the practical perspective of the main mission objective of evangelisation, the mission hospital was not the place for the terminally ill or permanently insane. To put it bluntly, dying patients created bad publicity and would not be useful as publicists for the mission. However, Christian charity and the value of individual conversion even on a deathbed demanded that the mission hospital should accept all patients, including the dying. For those who believed in the eternal damnation of the unconverted, this was particularly important. During the early period of the mission, the missionaries were very keen to ensure that patients did not die on mission premises, believing that this would mark the hospitals as houses of death that no patients would enter afterwards. However, even during the formative years of the mission, the missionaries sometimes had to take in terminally ill patients. W.P. Livingstone described a dialogue between Laws and a dying patient in 1883. The doctor had made the case for an amputation at the hip joint, but both the patient and "his friend" had refused to consent to this. Laws could only bandage and give opiate to the man.[162]

It should be noted that the policy of not admitting terminally ill patients was common in Victorian Britain. As Brown has pointed out, hospitals in nineteenth-century England and Wales would often refuse to admit those cases that were regarded as hopeless or chronic. Voluntary hospitals refused to accept

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161 Laws 1934, p. 123.

162 Livingstone 1921, pp. 210-211. Whilst dying, the man reportedly asked, "Where am I going, white man?" "Ay, whither away!" replied Laws. The narrative suggests that for Laws, death for pagans probably meant a Christless eternity. For the missionaries' general refusal to admit the insane to their hospitals, see Vaughan 1982.

dying patients for fear that they would inflate mortality figures and consequently decrease their funding, while teaching hospitals tended to select patients largely on the basis of medical interest.[163]

Regardless of missionary wishes, local therapy managers as well as colonial "refereeing agents" continued to send seriously ill individuals to the missionaries.[164] As has been noted elsewhere, missionary medicine was often regarded as the last resort among the therapy alternatives open to Africans. The missionary hospital, which for Europeans was a centre of superior and benign Western medicine, was for most Africans on the margins of medical culture. It was an alien place of alternative therapy, notable for its amputations and other surgical interventions on the body, some of which were remarkably successful, others were abominable, and many were fatal. However, the very fact that the mission hospital was often the last resort after all other therapies had failed may have actually mitigated the damage caused to mission's reputation if people died there. Things were arguably different if a patient was taken to the missionaries in the first place without recourse to local therapies, and then died at the station. When Agnes Fraser noted that only four of her patients during 1902 had died, she explained that the low patient mortality was the result of "*marvellous recuperative powers of the native*" rather than the potency of her medicines.[165]

If a patient died alone at the Institution, Laws would send his or her effects to the next of kin if he knew them. In cases where patients had been referred to the hospital by the colonial administration or European employers, he forwarded the effects to them.[166] During the influenza epidemic, the deaths in the Institution area placed the staff, associates and patients under considerable strain. When the epidemic was at its worst, Laws received a message from his hospital assistant that he could not find enough men who were capable of digging graves. When Laws went to the cemetery, he found *"one strong man & some convalescents at three graves"*. Some he had to send home to bed, *"less they shd. fill graves as well as dig them"*.[167]

Missionaries rarely provided statistics of patient deaths in the hospitals, and never wrote of deaths being due to erroneous or inadequate treatment. A rare unpublished statistic of mission hospital was provided in 1925, when Wilson reported from Chitambo to the Principal Medical Officer of Northern

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163 Brown 2004, pp. 338-339.

164 See for example Henderson 18 November 1908. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1909, pp. 9-10; For similar trends in Malamulo Mission Hospital, see Sayenda 1989.

165 Fraser however added, *"Of course, it is impossible to know what happens eventually to the bad cases that come about,"* When the first midwifery case taken to the Loudon station died of sudden tetanus, she feared that this would seriously damage her reputation as a healer. However, midwifery and other cases continued to come to her for treatment, including the brother of the dead woman, who paid a goat for therapy. Fraser suggested that her reputation was saved because the people had seen her practice and furthermore, in the case that turned fatal, she had *"warned the mother that I feared serious after-results might occur as the result of the septic treatment she had been subjected to in the village"*. *Annual Report for 1902*, p. 39.

166 Laws to Resident, Mzimba, 19 February 1917. MNA 47/LIM/1/1/17, 852.

167 Laws to Hardie 27 March 1919. AUL, Robert Laws Papers, Box 1.

Rhodesia the number of quarterly in-patients admitted between October and December. During this time, the twelve-bed hospital had an average of over twenty inpatients. On October 1, twelve men and six women were being treated. During the course of three months, thirty-two men and fourteen women were admitted, bringing the total number of in-patients to sixty-four. Of these, twenty remained in hospital at the end of December, six "ran away or left", eight "improved on dismissal", six died, and twenty-four were "dismissed well".[168] Of the forty-four inpatients who left the hospital, at that time, 54.4 per cent left "cured" (in the doctor's opinion), 18.2 per cent "improved", 13.6 per cent "ran away" or left unimproved, and 13.6 per cent died. Although these figures are only an incomplete sample, it seems clear that even though they were not mentioned in missionary publications, many patients did die in the mission hospitals.

In mission propaganda, deaths were generally attributed to a patient's late arrival at the hospital, the "tampering" of "native doctors", refusal to submit to an operation, or an incurable disease. Another explanation, put forth by Laws and W.P. Livingstone in 1920, was psychological: many patients "with some internal complaint" believed that they had been bewitched. These patients believed that they would die no matter how they were treated.[169] The missionary doctors who subscribed to this theory thus believed in the deadliness of witchcraft beliefs. This "placebo" theory of witchcraft, effectively cleared the doctors of final responsibility. Western medicine for all its techniques and therapeutics was unable to save those people who had neither the faith nor the will-power required for recovery. Such cases, which were regarded as being common at the DGMH, suggest that these patients were desperate and had given up almost all hope even before arriving at the hospital, as a last resort. Pain, the effects of drugs, the fear of an alien hospital and its ordered space, fear of Europeans and their therapies, difficulty in communication, a loss of control and a lack of contact with kin and friends were among other factors that impacted upon the psychological state of many critically ill patients. These factors, however, were not discussed in the missionary writings, which mentioned these patients' demise only in passing.

9.5 Therapeutic relationships and mission networks

A successful medical exchange between missionaries and a new patient or therapy management group was often seen as the foundation of an ongoing relationship. In the new districts, a patient from a distant village who had been treated successfully would be the best possible advertisement for the mission. As Butchart has noted, utilising patients as publicists was a key nineteenth-

168 Extract of Quarterly Statement to Dr May for Oct. 1 – Dec. 31 1925. Wilson to Laws 18 January 1926. MNA 47/LIM/1/1/35. In 1902, Agnes Fraser reported that during the year, only four of her patients had died – three of them children – a number she considered to be very low. *Annual Report for 1902*, p. 39.

169 Livingstone 1921, pp. 364-365.

century missionary strategy.[170] This continued to be the policy in Livingstonia during its expansion in the early 1900s. In 1902 in Mwenzo, Chisholm reported that while the total number of patients had been decreasing, serious cases and those patients travelling from a considerable distance were becoming more common. Some patients had travelled twenty miles to be treated. One of them was badly injured after falling from a tree and remained as an in-patient for three weeks. Contrary to Chisholm's expectations, the patient recovered. Another long-distance in-patient was carried in by his "friends". The doctor believed that "*these cases give us the freedom of a village*" but regretted that at that time the mission had no teachers to send to these villages. The population of the Mwenzo area were moving further inland and into German territory, both because of the needs of slash-and-burn cultivation and to avoid forced recruitment as carriers on the Stevenson Road.[171] In these circumstances, missionary therapy would potentially enable the creation of valuable relationships between missionaries and those people on the move. It was Chisholm's aim to use these contacts in the future by sending teachers and evangelists out to the villages of former patients and their therapy managers. By 1904, fifty-nine teachers and monitors were employed in thirty-two schools in the Mwenzo district.[172]

After a treatment had been deemed a success, the missionaries' chances of advertising their therapeutics for that particular ailment improved. Chisholm wrote in 1904 that while touring the villages, he saw a woman with a large tumour similar to one he had successfully removed some time ago. He asked her to be sent to Mwenzo to have it removed, and her parents were in favour of this.[173] In 1908, Nurse Henderson reported that in Kasungu, after a woman had recovered from serious burns at the mission station, she told her friends that, "*the medicine of the Europeans have done it*". The long-distance patients included two young men from three days' journey away, who had been treated for ulcers, and were reported to be recovering slowly.[174]

However, sometimes the therapy managers flatly refused to consent to European treatment. In 1907 in Kasungu this led to an overt clash when Prentice and Nurse Henderson tried to treat a woman in a village about one day's journey from the mission station. They went to her hut and offered to help, but the relatives refused to allow this. Furthermore, Henderson wrote, "*her relations dragged her out in her helpless condition, saying that we had come to harm her.*" Prentice negotiated for a long time "*with the chief of the village, and finally they accepted our help and offered to be quite friendly*".[175] In this case

170 Butchart 1998, p. 79.
171 Chisholm 10 April 1902. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee, 1902, pp. 33-35.
172 Chisholm to Daly 25 Jan. – 10 March 1904. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee 1904, p. 62.
173 Ibid., p. 57. See also Prentice to Smith 21 November 1899. NLS, Acc. 7548 D 69.
174 Henderson 18 November 1908. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1909, pp. 9-10.
175 Henderson 4 December 1907. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1908, p. 35.

missionary intervention in the patient's home was interpreted as downright hostility to begin with. However, following successful negotiations between the doctor and the headman of the village the woman was taken to the mission station for treatment. The chief or the headman seems to have been either the leading therapy manager himself or in a position to persuade or coerce the woman's family into accepting missionary therapy. Since this meant moving the patient one day's journey from her home, it was emotionally and economically trying for the therapy management group who would have to visit and support her. If missionary treatment failed in such a case, it could ruin the reputation of the missionary in the village and strengthen the arguments of those who opposed mission medicine.

Treating influential chiefs, headmen and their families continued to provide the most potential for mission expansion. In 1906, Chisholm reported that one headman's brother, who had been badly mauled by a leopard, was being treated at Mwenzo and had been accompanied by his "wives and friends". Chisholm believed that he would recover, and hoped that the patient's and his brother's attitude would change from their previous "passive hostility" towards the mission.[176]

Therapeutic connections linked both the surrounding villages with the missionary hospitals, and other mission districts with the central hospital at the Institution. Even before the establishment of the DGMH, cases were sent to the plateau from Ekwendeni, where Elmslie had adopted the active role of a refereeing agent for the Institution hospital. In 1906, Margaret Stuart wrote from Ekwendeni:

> This morning…an old man appeared at the dispensary having a smile on his face like a May morning and leading a fine fat-tailed sheep by a bit of bark string. He turned out to be the father of a boy just returned from undergoing a successful operation at Kondowe. The sheep was to be sent to thank Dr Laws for healing his child.[177]

The reputation of Institution surgeons was propagated by the former mission pupils, apprentices and mission employees. Nurse Ballantyne believed in 1907 that news of successful surgical operations travelled quickly, and often resulted in more patients travelling some distance to receive treatment at the Institute. A former mission pupil would sometimes come to the mission for treatment after many years and from a considerable distance away.[178] The remote location at Khondowe made consultations with Laws and his colleagues difficult, but may also have enhanced their reputation. The idea that some of the most potent

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[176] Chisholm 12 November 1906. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1907, p. 18.

[177] Stuart 10 July 1906. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1906, pp. 108-109.

[178] Ballantyne 1 November 1906. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1907, p. 16. In 1906 Jessie Fiddes addressed the patients in the Institution dispensary, asking where they came from. She showed them the New Testament asked whether they could read. To Fiddes' astonishment, a woman with a baby said she could read and it transpired she had been taught by Mrs Laws many years earlier. Extract of Fiddes to Barr 18 September 1906. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1906, p. 119.

medicine men and women were to be found among neighbouring or distant peoples was widespread in South-Central Africa. The Phoka people at Khondowe (as previously noted) had a reputation for their knowledge of medicines. In north-eastern Rhodesia during the 1950s it was commonly believed that the Nyasaland people had particularly powerful medicines.[179]

Laws recalled in his reminiscences that after the establishment of the DGMH, one man had travelled over one hundred miles from the north-east, in order to be treated. However, the reputation of Laws and other missionaries, or their ability to satisfy their patients' needs should not be overestimated. The man from a hundred miles away told the doctors:

> that there was a snake moving in his abdomen, so he had come in order that the doctor might take it out, showing meanwhile by his gestures his conception of the size of the opening he was prepared to submit to in the process. He seemed very much disappointed when the doctor told him he would like to be sure first what he was to find before he attempted such an operation.[180]

What treatments were eventually agreed upon is not clear. However, it is significant that patients could have very specific ideas about and make very specific demands of missionary medicine and surgery – for example, the size of incision the surgeon would be allowed to make. The doctors, nurses and medical assistants had to negotiate in such situations and try to establish a common understanding and agreement on illness and therapy.

It should be kept in mind that for every protagonist of mission medicine at the Institution, there would be another describing disease and death in the highlands, or criticising missionary surgery. The fact that a father in the Ekwendeni region in 1906 decided to send his son to the Institution for an operation was probably the outcome of a difficult decision-making process. However, the payment of sheep to Laws confirmed that the therapy managers were satisfied on this particular occasion.

Workers at the Institution played an important part in the dissemination of mission Christianity across the Khondowe Plateau.[181] Economic opportunities attracted workers, who become familiar with evangelism and missionary medicine and who were essential in spreading news, rumours and stories – both good and bad – about the mission during their travels and in their home districts.

Obstetrics, midwifery and infant care continued to be a thorny field of co-operation between missionaries and Africans, including African Christians. This is illustrated by Nurse Ballantyne's account of a case from 1907:

> Last week I got my first case since coming out to come into the maternity room. She is the wife of one of the native teachers, rather a stiff-necked man...who was not just willing his wife should come, even to spare her pain…She was glad to come, and was very happy with us. Her former wound healed up, and she has gone home quite well and strong. The daily washing of the baby caused great alarm to them both.

179 Marwick 1970, p. 84.
180 Laws 1934, p. 125.
181 Oral testimony, S.M., 11 July 2004.

> Each day they examined their child to see what harm had I done it. One day I received a message from the father saying he thought the child was out in the back and I had better stop. Of course, I did not, and now I am visiting the mother and find she is trying to do as I showed her. This I look on as a great thing and likely to help others to do the same.[182]

The parents' concern and suspicion about the daily washing of the baby was probably due to certain common beliefs and practices within the region. According to Banda and Young, in both Chewa and Tumbuka societies, the newborn baby is regarded as being particularly vulnerable, and must be protected through the use of specific medicines and procedures. A local healer is frequently called upon to supervise the cutting of a baby's hair and to administer prophylactic medicine against bewitchment.[183] In this light, it is understandable that the actions and intentions of the European nurse were scrutinised carefully. It is noteworthy that in this case, the father, who was a Christian teacher, appears to have been more suspicious than his wife, who it seems may have been willing to adopt some of Ballantyne's practices. In theory, the missionaries' treatment of newborn and infants could be seen as similar, complementary or conflicting practice to African healers' fortification of babies, but possible interpretations and decisions in this area must have varied considerably from family to family. The case does suggest, however, that mission nurses had more opportunities than male doctors to establish a therapeutic relationship in the fields of midwifery and childcare.[184]

In the 1920s, the mission nurses increasingly concentrated upon infant and child care. A number of infants in missionaries' care had lost their mothers through hunger, disease or birth complications. For example, several motherless babies had been brought to the Institution in 1925. Nurse Cole wrote from Loudon, in January 1926, that following the previous year's drought and famine, one "little starvation baby" whose mother had died of hunger, was being treated at the mission hospital.[185] These types of cases seem to have been prominent in the aftermath of a famine.

Teachers, evangelists and members of the Christian community, especially those educated at the Institution, generally had, the closest ties to mission medicine, and were supposed to rely upon it even after they had moved away from the mission stations. A mission teacher at Deep Bay was hospitalised at the Institution for several months after he had been shot in the abdomen by a drunken policeman in 1903.[186] The distance to the hospital was often substantial for many Christians, and the doctors were not always available. In 1917, Laws reported the death of a Ngoni evangelist Daniel Nhlane from dysentery,

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182 Ballantyne 3 February 1907. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1907, pp. 28-29.

183 Banda and Young 1946, pp. 19-21.

184 See Chisholm 29 November 1907. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1908, p. 29.

185 Laws to Martin 30 December 1925. MNA 47/LIM/1/1/25a,, 313; Cole to Lee 12 January 1926. NLS, MS. 7995.

186 Laws to Candy 20 November 1903 and 18 February 1904. MNA 47/LIM/1/1/5, 474, 522.

"contracted in the south". He had been carried to Kasungu, but Prentice was away. He was then taken to Loudon hospital, where he later died.[187]

Therapy management groups, Christian as well as non-Christian, would usually decide when and where a patient would be treated, but the decision-making process could sometimes result in conflict. In 1921, Nurse Cole reported from Loudon that a young evangelist, Liwa, had a "pain and swelling in his leg". Cole had wanted to *"let the pus out & had the things over twice, but a family jury sat on the case & decided it was not ripe."* Finally, in desperation, Cole was summoned and she managed to remove some, but not all of the pus.[188] The swelling of body parts, it should be noted, is a typical symptom of many ailments which were connected with moral transgression in Central African medical theory. The conflicts between relatives over therapy management decisions could sometimes be violent. In 1926 in Ekwendeni, it was reported that when a Christian elder went with a *machila* to fetch his wife to hospital, he was chased out of her village by his father-in-law. The missionaries, in turn, threatened the therapy managers with a murder charge at the Boma if the patient died. The woman died, leaving a baby to be treated at the mission hospital. The patient's relatives were taken to the Boma to be tried at the colonial court.[189]

There were only limited opportunities for missionaries to encourage Africans from outlying districts to go to the hospital. Mamie Martin wrote of her frustration during an *ulendo* to South Kasangazi in 1923. In a village high in the hills, requests for medicine, chiefly for ulcers, were made to the mission party. Some small children were extremely ulcerated, and Martin tried to persuade their mothers to take them to the hospital. They replied that the hospital was too far away and that the monkeys would destroy their gardens in their absence. Martin said that she was afraid that the children's legs could be spoilt, but could not say that she actually believed that the children would die of blood poisoning. She believed that such arguments would have been *"turned into a threat in their own minds – believing that if they refused to take their children to the hospital I would put the children under a curse so that they would die."* [190] By this time, there was an increasing awareness among missionaries about the possible local interpretations of their statements. The threatening language typical of the pioneer doctors – who often said bluntly that people would die if they did not come to be treated or submit to the amputation – was now considered to be counter-productive. Such language could potentially leave missionary personnel open to witchcraft accusations, and was generally detrimental to the missionary cause.

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187 Laws to Innes 21 February 1917. MNA 47/LIM/1/1/17, 862; Fraser 1925, pp. 207-209.

188 Cole to Laws 14 March 1921. MNA 47/LIM/1/1/44.

189 Jack Martin 14 November, Mamie Martin 22 November 1926. Sinclair 2002, p. 260.

190 Martin 14 April 1923. Sinclair 2002, p. 133.

10 PUBLIC HEALTH, HYGIENE AND COLONIALISM, 1890-1930

10.1 Missionary health and hygiene after the turn of the century

During the first decade of the twentieth century, the general health of Europeans in British Central Africa was improving.[1] This progress was attributed to improvements in housing, sanitation, and both preventive and curative medicine. The introduction of quinine bihydrochlorate (which could be administered by hypodermic injections) was considered to be a major improvement in the treatment of malarial fevers. The medical historian Michael Gelfand has emphasised the significant contribution of better housing and leave conditions as well as preventive antimalarial measures to the overall improvement in European health in British Central Africa at the turn of the century.[2]

During the 1890s, as has been noted, there had been little therapeutic success against fevers in general and blackwater fever in particular. Medical officers and missionary doctors saw housing reforms and shorter periods of service as means of improving European public health. At the Livingstonia Committee meeting in 1897, Elmslie, as a doctor, defended the proposal to shorten the period of service to three years.[3] The Committee sought doctors'

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1 In the Protectorate, the overall European mortality rate dropped from about eight per cent in 1897 to about two per cent in 1908 and "well under 2 per cent" by 1930s. *Report by Consul…Sharpe on the Trade and General Condition of the British Central African Protectorate, 1896-1897,* Cmd. 8438, p. 1; *Nyasaland Protectorate, Report of Commissioner for 1907-8,* Cmd. 3729, p. 19. Murray 1932, p. 381. However, the high mortality rate among the newly-arrived Catholic missionaries in the Protectorate in the early century should be noted. According to Linden, there were nine deaths among the missionaries between 1906 and 1908, with an overall mortality among Catholic missionaries during that period of fifteen per cent. Linden 1974, p. 72.

2 *Report on Foreign Missions for 1900,* pp. 100- 101; Gelfand 1984, p. 258.

3 Elmslie to Laws 4 January 1898. NLS, Acc. 7548, D 67; "The New Scourge of Africa", *The Scotsman,* 26 July 1898. Newspaper cutting, NLS, MS. 7901, 48.

opinions on the appropriate length of terms of service and furloughs. Chisholm argued that a five-year term was too long not only for those at the lakeshore, but also for those serving on inland stations, emphasising the possible detrimental effect of tropical climate on nervous and mental health, which predisposed people to physical illness.[4]

The Committee agreed not to shorten the furloughs, but the terms of service remained at five years both on the lakeshore and in the hills, much to the doctors' disappointment. Nevertheless, the Livingstonia doctors gradually became more confident in their treatment of blackwater fever. In 1903, Prentice noted that mortality from this disease had clearly decreased. He had no objections to successfully recovered "B.W." patients, returning to the field. He argued, that it was medically interesting to study cases of complete recovery from very serious illness.[5]

Marriage and health

In April 1897, James Henderson wrote optimistically to his fiancée about the health conditions she would face in Malawi. He held that "ladies" were safe enough at Livingstonia. At this time, male missionaries had suffered heavily, and Henderson's letter suggests that the old idea that women were able to withstand malaria better than men may have had some lasting currency well into the 1890s.[6] However, in 1900, the Mission Council of Livingstonia agreed that women missionaries should never be posted beyond the reach of medical aid. The safety of missionary homes was deemed to be of the utmost importance. After the mission had been heavily criticised by friends of the late Mrs Cross, there was an urgent need to demonstrate that Livingstonia took care of its own. Thomas Binnie wrote to Laws that a true account of the circumstances of Mrs Cross's death could be told only to a trusted few, as it would be so painful that it would cause resentment.[7] As a result, compulsory medical examinations were introduced for missionary wives who were leaving for Africa.

Male missionaries occasionally made personal requests not to be stationed alone, but no universal guarantees were given and these cases were controversial. At the Mission Council meeting in October 1898 (when the extension of the mission and the manning of the new stations was considered), Rev. Alexander Dewar from Mwenzo demanded that it was his right to have access to medical care at the station. The Mission Council, although sympathetic to Dewar's position, agreed that it was impossible to pursue a policy that every missionary had a right to be stationed with a "medical man". Following this

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4 Chisholm 13 January 1903. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee, 1903, pp. 41-42.

5 Prentice 27 June and 10 September 1903. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee 1903, pp. 102, 123.

6 Henderson to Davidson 27 April 1897. Ballantyne and Shepherd (eds.) 1968, p. 244.

7 Minutes of the Livingstonia Mission Council 29 October–2 November 1900. NLS, MS. 7883, 174; Binnie to Laws February 1891 [n.d.]. NLS, MS. 7899, 9.

logic, they argued, every doctor should also have the right to be near another doctor in times of sickness. The Council pointed out that, in the recent past, only one ordained missionary had died, while four doctors had died, two of whom had received no medical help, and that a further two doctors had been invalided. It was an acknowledged fact that doctors were in a particularly dangerous situation when they themselves fell ill. The Council proposed that both Kasungu and Mwenzo stations should eventually be manned by married missionary doctors (Prentice at Kasungu and the newly-appointed James Chisholm at Mwenzo), and that the Karonga station should have both an ordained man and a doctor on its staff. This plan indirectly recognised that the burden of treating missionary doctors would lie with their wives: posting a married missionary to a distant mission station was a sound strategy from a medical point of view.[8]

Although Livingstonia publication did not overtly stress that the medical missionaries' first priority was the care of European missionaries and their families, this was acknowledged by their contemporaries during the 1890s. James Johnston, a Scottish missionary doctor from Jamaica who travelled through the region in the early 1890s, was very sceptical about the possibility of effective practice among the Africans, and believed that the presence of a qualified medical missionary in Central Africa was justifiable only where there were European missionaries to be looked after. Sir Harry Johnston, who praised missionary medicine, in general, pointed out the importance of mission medical services to missionary families. Medical security made marriages in the mission circles more common and created the stability that the mission authorities desired. Sir Harry saw that the married missionary actually became a missionary colonist, and so medical missionaries served the interest of missionary colonisation, although he was worried about the dangers of European degeneration which might follow with white women in particular, being exposed to African "animal natures and instincts".[9] Medical security promoted marriage, but missionary marriage was also seen to promote health, particularly through improvements in diet, housing and nursing as well as securing sexual morality and preventing unacceptable mixed marriages.[10]

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8 Minutes of the Mission Council 25 October 1898. NLS, Acc. 7548 D 69, Letters to the Livingstonia Sub-Committee, 1898-1900, No. 82. In the early 1900s, when the mission planned expansion into north-eastern Rhodesia, Elmslie and Laws continued to advocate stationing European missionaries in pairs at least, while Fraser would have preferred one-man stations and further expansion. Thompson 1995, pp. 137-138.

9 Johnston 1897, pp. 199-200; Johnston 1969, pp. 334-336; Good 2004, p. 103. In Livingstonia, missionaries frequently married each other. Of six unmarried women appointed to Livingstonia between 1894 and 1901, five married Livingstonia missionaries and one was invalided home. McIntosh 1993, p. 135.

10 Hall 2004, p.60; Hastings 1994, pp. 260-261; Kirkwood 1993, p.26. In the 1880s there were rumours of "former mission man" having an African concubine. Scott to Laws 30 October 1884. NLS, Acc. 9220, (1) (ii). In defending his and his fiancée's decision to come to Africa together in 1885, Cross argued that *"if I go alone I will not enjoy such good health as I would otherwise do! I have never been accustomed cooking my own food or looking after its preparation"*. Cross also quoted Dr Hannington saying that he would not have survived out of Africa without his wives' nursing on the way out. Cross to Laws 11 July 1885. NLS, Acc. 9220 (1) (iii).

Healthy housing

Mission houses had been deemed to be of vital importance to the continued health and well-being of the staff from the outset. It has been noted how Robert Laws wasted no time in erecting a two-storey house at Cape Maclear to elevate sleeping quarters as far above the ground as possible. Two-storey houses were considered to be significantly cooler and healthier.[11]

Throughout the late nineteenth century, the station houses were frequently regarded to be health hazards. Thatched roofs in particular were considered to be "malarious", and housing reforms were proposed during the late 1880s. In 1890, Thomas Binnie of the Livingstonia Committee, along with Walter Elmslie, drew up plans for new houses. All stations, Laws argued in 1892, should have at least two or three dwelling houses made of brick or stone, with iron roofs.[12] It is significant that at this time Laws believed that preventive measures including proper housing and location, and European company would ensure health adequately and would be significantly cheaper than investing in doctors and hospitals for each station.

The model house did not become a reality on many mission stations during the 1890s at least. For example, in 1897 at Bandawe, Dr Prentice was reported to have lived in "the most unhealthy [house] in Africa". There was no effective ventilation in Prentice's house, and the thatched roof was occupied by "thousands of bats". The house was believed to have undermined the doctor's health to such an extent that he was advised to visit the hills to recover.[13]

In 1899, Rev. Dewar strongly condemned the large, hot and costly house at the Karonga station.[14] A month after Dewar's complaint, the Livingstonia Mission Council agreed with his criticisms, and presented a detailed condemnation of the Karonga house. They especially criticised the foundation, which was:

> laid in a black soil impregnated with vegetable matter...the space under the floor is insufficiently ventilated, so that damp offensive emanations from the soil fill the rooms, and must injure the health of those occupying it.

Furthermore, there were no proper verandahs, and the sides of the house were exposed to both the sun and rain. There was no back door, which was

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11 Fraser 6 January 1903. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee, 1903, pp. 42-45.

12 *Report on Foreign Missions for 1890*, pp. 10, 95-96. Laws, (*Confidential) Memorandum regarding the organisation and development of the Livingstonia Mission*, 1892. These schemes stressed the use of corrugated iron roofs, hard-burned bricks, the building of verandahs and the general importance of ventilation. The site should be raised two to three feet above the ground. The ground below should be dried with trenches. Floors should be made of hard-burned bricks, grouted with lime or cement. Roof verandahs should be kept open for ventilation, and for the same reason, all rooms should have fireplaces. For the importance of fire against malaria, as well for ventilation, see Cross 1897, pp. 6-7.

13 Elmslie to Laws 1 April 1897. NLS, Acc. 7548 D 67.

14 Dewar to Smith 30 October 1899. NLS, Acc. 7548 D 69, Letters to the Livingstonia Sub-Committee, 1898-1900, 91.

considered to be very inconvenient because the dispensary and prayer hall were all part of the same building. Buildings for "native use" were to be detached from European dwelling houses. Dewar was advised to erect a verandah – essential for health and comfort – at once. The Council condemned the design of the Karonga house (which was apparently to become the standard design at the new Institution) as being unsuitable, unhealthy, and too expensive. This suggests that the Council believed that Laws, whose ambitious building schemes at the Institution were judged to hamper the work at other stations, was ultimately responsible for the inadequate housing plans.[15]

Constructing healthy and comfortable European houses usually meant erecting large and expensive buildings. In 1903, Donald Fraser's plans for a residential house at the Loudon station were criticised for being too expensive. Fraser defended his £700 plan for a two-storey building with wooden floors, and compared it with the house of the Elmslies in Ekwendeni, which had reportedly cost around £800. Such a house, Fraser argued, was healthier and more comfortable, implicitly arguing that the Frasers were entitled to the same standards of living, health and comfort as the Elmslies. The combined cost of the rest of the station buildings, including a hospital and a church was £1,100.[16] In 1911, the European residential buildings at the Institution were valued at £5,580, with the most expensive residential buildings being Dr Innes's house (£1,350) and first part of the uncompleted Stone House of Laws (£1,030). In contrast, "native dwelling houses" were worth £1,162, and four brick churches, £440.[17]

Africans as sources of infection

By 1900, the transmission of malaria by mosquitoes had been recognised by even the most conservative missionary doctors, and the earlier emphasis on the general healthiness of local conditions was replaced by a search to neutralise definite causal agents of disease. Ronald Ross had demonstrated in 1897 that the malaria parasite was actively transmitted by inoculation both from

15 Minutes of the Mission Council 6-9 November 1899. NLS, Acc. 7548 D 69, Letters to the Livingstonia Sub-Committee, 1898–1900, 92. Laws was not present at this Council meeting. Smaller missionary houses built in the early 1920s typically consisted of four rooms, a store and a large verandah (konde). Martin 24 October 1922, in Sinclair 2002, p. 101. Wide verandahs protected people from the dangerous rays of the sun. Cf. Curtin 1992, p. 245.

16 Fraser 24 December 1903. NLS, Acc. 7548 D70, Letters to the Sub-Committee, 1904, pp. 38-40.

17 General Assets of the Overtoun Institution at November 30, 1911. MNA 47 /LIM/1/1/13, 959. In contrast to the Scottish missionaries of Livingstonia and Blantyre, the UMCA missionaries in Likoma Island lived in comparative poverty, stressing simple living and sacrifice until the early twentieth century. They were generally criticised by their European contemporaries who believed that they endangered their health in a futile and dangerous attempt to live like the Africans. Good 2004, pp. 92-93.

mosquito to man, and from man to mosquito.[18] Thus, not only mosquitoes, but also people were potential carriers of the disease. At the turn of the century, malariologists presented three main strategies for combating malaria. One, initially advocated by Ross, emphasised attacking the mosquito vector by destroying and controlling mosquitoes in European-inhabited areas. The second strategy, devised by Robert Koch, advocated mass quininization of the indigenous population in order to destroy the source of infection, the parasite in their blood. The third approach, presented by the British Royal Society scientists, was based on a premise that both mass chemotherapy and mosquito control were inadequate. To secure European health, it was essential to segregate them from the African population, and above all from African children, who were erroneously considered to be the prime sources of infection. In practice, Curtin has pointed out, these separate theories "soon became confused with one another and with older medical views that persisted",[19] a development which was apparent in the antimalarial policies adopted at Livingstonia.

In 1901, the Livingstonia journal published new instructions for housing on mission stations. In these plans, "native quarters" were explicitly identified as a potential source of infection. Both because of "general hygiene and malaria", these quarters were not to be located near the houses of the European staff. *"If this is unavoidable then use quinine freely among the natives on the station as a prophylactic both before and after fever develops, and permit no pools or puddles in the vicinity as breeding grounds for mosquitoes"*,[20] added the anonymous writer, for whom quinine should be administered "freely" to the African population, only if they could not be effectively segregated, thus posing a danger to European health. This approach synthesised all the main theories of eminent malariologists, stressing first segregation, then quininization and anti-mosquito measures. Although quinine had become cheaper by the early twentieth century, the costs of providing quinine to all African residents on the mission stations were apparently too high in Livingstonia to undertake this mass quininization approach. However, in 1912, Laws administered quinine to all pupils and workers at the Institution at the beginning of the school term and after holidays.[21]

After the turn of the century, the plans for new stations increasingly took into consideration the location of the African population as one of the factors affecting health. When selecting the site of the mission in Loudon, Agnes Fraser assessed its health merits:

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18 Worboys 1996, p. 193. In February 1900, Elmslie wrote to a recently arrived missionary that *"The chief mode of catching fever undoubtedly is through mosquito bites"* but still emphasised the importance of avoiding "overtaxing energies", staying in damp clothes and exposure to the sun. Elmslie to MacGregor 16 February 1900, MNA 47/LIM/1/1/3.

19 Curtin 1992, pp. 238-240. African children were believed to be "reservoirs of malaria" as late as in the 1930s. Murray 1932, p. 371.

20 *The Aurora*, June 1901, pp. 15-16.

21 Laws to Dr Hearsay 23 March 1912. MNA 47/LIM/1/1/13, 924.

> The water is good as far as African water goes, and though it has not the bracing air of Hora, we are able…to choose as much ground as we want, and consequently to keep villages, and with them much of the risk of malarial infection, at a safe distance. ...a great point to me in its favour is that the land seems to promise very well for the growing of fruit and vegetables, a health point of no slight importance.[22]

Thus, occupying more space, and establishing distance between mission houses and African villages, was seen to be essential to a healthy station. The station should be near centres of population, but crucially at a “safe distance” from them. Furthermore, the cultivation of fruit and vegetables had, by this time, been recognised as means of securing health, while very high elevation and running water close to the station were no longer deemed to be so important.[23]

Developments in tropical biomedicine resulted not only in the anti-mosquito measures but also contributed to a new hygienic segregation, in the missionary mind at least, between the Europeans and Africans living and working on a mission station. In the older theories of fever, which had stressed the importance of soil, climate and careful living, only rarely were the Africans explicitly identified as being a major threat to European health. As Warwick Anderson has pointed out, with the development of tropical medicine at the turn of the century, the emphasis shifted from “medical ecology of colonialism” to a concern with the medical meaning of interpersonal relations. Malaria was not the only disease the study of which contributed to this development, but arguably, it was the most influential.[24]

The change in medical paradigm was apparent in everyday life on the mission stations. Rev. David Sibandwe remarked to T.J. Thompson in an interview in 1971 that in the 1920s, “even African ministers did not stay in European houses”.[25] In his memories of the Lubwa station, the evangelist and reverend P.B. Mushindo recalled that Africans had to wait outside at some distance from a European house until called, and that some Europeans would not eat with Africans. The Lubwa church had separate seats for Europeans, who drank from the communion cup before Africans.[26] Such racist social conventions, which were prominent in the inter-war years, stemmed, in part, from the idea of African people as a source of disease. In 1936, the Joint Medical Committee in the Protectorate, stressed in its report to the Livingstonia Mission Council that in addition to meticulous mosquito screening of the mission

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22 Fraser, January 1903 [n.d.], NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee, 1903, pp. 48-49.

23 Prentice seconded Dr Fraser’s opinion of the healthiness of Loudon, adding: *"One misses the mountains of Hora, but, of course, we don’t come out here to evangelise the hills."* Prentice 25 June 1903. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee, 1903, pp. 100-101.

24 Anderson 1992; Curtin 1992. Good has pointed attention to this development in the UMCA stations. Good 2004, pp. 16, 221n39, 415-417. In 1932, European travellers in the Protectorate were advised to camp at least half a mile from African villages or stagnant water. Murray 1932, p. 371.

25 Quoted in Thompson 1995, pp. 204.

26 Ibid., pp. 203-204.

houses and facilities, *"care should be taken not to have infected natives inside screened rooms for long periods."*, an order which was written in red ink.[27]

As a person could be infected with malaria for a long period without displaying any obvious symptoms, and an accurate diagnosis of the infection required microscopic investigation, disease prevention tended to enforce the general segregation of Europeans and Africans. Segregation had been apparent for a long time in the mission's provision of medical services. European patients were normally treated either at home or at the doctor's house. Where Europeans were admitted to the mission hospital there was sometimes a separate European ward. In Kasungu Prentice had built a European ward at his own expense, and in 1923 he reported that as it had been *"polluted by Natives"*, the ward could no longer be used by Europeans.[28]

The differences between the views held by the older and younger missionaries about healthy European accommodation were highlighted in a debate in the Mission Council over European nurses' quarters at the planned David Gordon Memorial Hospital. The original plan of the hospital drawn up in Scotland was heavily criticised for placing the nurses' quarters and the patients' accommodation within the same building. The proposed space for the nurses' rooms were *"too small for this climate to secure health and comfort for one on whom there may be frequent calls for night work."* The nurses would require, in the Council's opinion, larger quarters with a spare bedroom, kitchen, store and a servant girls' room. Connecting these rooms with the out-patient department was condemned particularly because of concern that patients would bring dangerous ticks into the building. Elmslie and Laws proposed that it would be most practical and economical to accommodate the nurse on the second storey. Upstairs, the nurses' rooms would be *"practically cut from the native entrances and corridors"*. Laws' plan demonstrates how in "two-decker" buildings the space and movement of African servants was controlled and separated from Europeans. However, Dr Innes disagreed with Laws and demanded that a separate house for nurses was a necessity, arguing that, *"The growing risk to health from various infectious diseases, though perhaps lessened by residence in an upper storey, is by no means removed, and at the same time residence in a separate building was admitted to be the best."* He also believed that it would actually prove to be a cheaper solution. Furthermore, a separate nurses' house could be used as a European ward in need. In the end, Elmslie and Laws were outvoted five to two.[29]

The issue of the nurses' accommodation continued to be a matter of heated debate in 1914, when the DGMH was still under construction and only £1,400 of the £5,000 budget remained. The proposed large nurses' house, with an attached European ward, would cost an estimated £1,000, leaving only £400 for the remaining wards and outhouses required to complete the hospital. Elmslie, Turner and Henderson argued that as European patients were rare, a

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27 Minutes of the Mission Council, August 1936. MNA 47/LIM/3/18.

28 Prentice to Ashcroft 13 July 1923. NLS, MS. 7886, 46.

29 Minutes of the Mission Council January 1908. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1908, pp. 62-64.

smaller nurses' house would be sufficient, but the matter was passed to the Building Committee.[30] It is revealing that according to the scheme preferred by Dr Innes, the leading doctor at the hospital, one fifth of the DGMH hospital fund would have been used to build a European nurses' house containing a European ward. Such policies were open to criticism from both the Committee and the donors, and in 1915, the Council defended their plans stating that, "*In no communication from Miss Gordon has there ever been a restriction to native patients, though primarily the money was given for this purpose…*" The Council also stressed that the care of mission staff and other Europeans was essential work and that, to date, it had been necessary to treat European patients in doctors' homes, which had caused significant inconvenience for doctors and their families.[31]

When the Foreign Mission Committee in 1916 eventually sanctioned the construction of two new general wards, one of which was to be used for nurses' accommodation and the other for European patients, the Council strongly opposed the decision, stating categorically that there was no need for more African in-patient accommodation, only for a nurses' house, wash-house and mortuary. In 1917, the FMC agreed to pay £250 for a separate nurses' house, and suggested that the two wards should be completed, with temporary European accommodation in one ward separated by a partition, and the second ward to be used as dormitory or a store until required by African patients. Such a compromise arrangement also satisfied Miss Gordon, who was anxious to see the hospital completed before her death.[32]

A healthy central station – Overtoun Institution

Securing a clean water supply was essential for a healthy station. During the first years of the Institution's construction at Khondowe, dysentery was common among both the pupils and workers. When Laws was on furlough in 1899–1900, he received a letter from Yuriah Chirwa, who was "capitao" at the station. Chirwa reported that all of the pupils were suffering from stomach-ache as a result of the water supply being contaminated by the workers. Europeans had their own drinking water carried from two miles away. Laws managed to secure £4,000 for a piped water supply from Lord Overtoun, which was completed amid celebrations in January 1904. The pumping of water uphill initially caused quite a sensation, but soon the piped water was regarded as commonplace by the people.[33]

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30 Minutes of the Mission Council 20 May 1914. MNA 47/LIM/3/17.

31 Minutes of the Mission Council 31 August 1915. MNA 47/LIM/3/17. It appears that the donors' original wishes were that £2,000 be spent on the construction of the building while the remaining £3,000 was to be used for its endowment. Daly to Laws 10 September 1902. NLS, MS. 7864, 321.

32 Minutes of the Mission Council 18 October 1916. MNA 47/LIM/3/17; Ashcroft to Laws 27 February 1917. NLS, MS. 7683, 4.

33 Livingstone 1921, pp. 297-305.

There is evidence that both electrical power and above all the water supply boosted the reputation of European medical power in general, and in particular, improved Laws' personal reputation. However, there was also a perception that tap water was "water for the whites". According to one informant:

> I heard from my grandmother that one day she had gone [to Livingstonia] to sell goods, while there got thirsty and refused to take tap water because it was water for the whites. And Laws, who was there, told her that she would get healed if she took the tap-water...After taking tap water maybe because of belief she said she got healed of "nyamakazi".[34]

During the second construction phase of the Institution (1901–06), Laws designed and built a large double storey "hygienic building" for the technical departments. Disapproving of "the ordinary native kraal, a focus of mud and filth" he planned a model farm homestead nearby.[35] The new industrial Institution was to be built according to the laws of hygiene, extending from housing to the water supply, from latrines to the planned European and African quarters.

In the 1910s, shallow trench latrines were dug under the supervision of Innes. The missionaries endeavoured to expand the system of latrines, deep pits or swallow trenches, to the nearby villages. In 1914, Innes addressed public meetings on village sanitation, and the Institution employed workers to supervise the condition of the latrines, as the local population was sometimes reluctant to use the new sanitation facilities.[36] In the early 1920s, in addition to hospital assistants and hospital orderlies, a number of sanitary workers were trained and employed by the Institution to look after the latrines and deal with any potential breeding grounds for mosquitoes. By the mid-1920s, Laws believed that the number of mosquitoes had clearly decreased, resulting in a "corresponding improvement in health."[37]

The movement of people and the freedom to build were controlled on the plateau. In 1915, Innes complained that some Africans had built their huts and grain stores on the hillside beneath the dining hall of the Doctor's house. They were ordered to move, as they had built without missionary permission. In the early 1920s, the mission agriculturalist Caseby admired the orderliness and cleanliness of the Institution. The main dangers to health came from diseases

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34 Oral testimony, S.M, 11 July 2004. For "nyamakazi", see Lwanda 2002, p. 58.

35 Livingstone 1921, pp. 297-305.

36 Overtoun Institution Senatus Minutes 11 June 1912 and 13 February 1914. MNA 47/LIM/3/32. Good has observed that in colonial Malawi, "latrine construction was not an unmixed blessing, for it could create other problems, not least the contamination of their immediate surroundings. Disgusted by insanitary conditions, some people simply avoided latrines." Good 2004, p. 392. The compulsory construction and use of latrines was often resisted, sometimes even by building bogus latrines to fool the inspectors. In his study of Northern Rhodesia, Marwick has suspected that the Chewa objection to pit-latrines was in part due to fear of "contagious" sorcery as sorcerers were generally believed to use materials of "dirt" from their prospective victims for the use of destructive magic. Marwick 1970, p. 75.

37 Laws to Principal Medical Officer, Tanganyika Territory (n.d.). MNA 47/LIM/1/1/25 (a), 45.

transmitted by mosquitoes, or by ticks and jiggers. In the 1920s, to avoid jiggers and jigger eggs, all pieces of clothing, even socks were meticulously ironed by the African house-servants. Quinine tablets were taken daily by all Europeans and the typical prophylactic quinine dosage had increased from the amount administered in the 1890s. In 1928, the standard dose for Jack Martin was five grains every night at dinner, and an extra five-grain dose in the morning if "run down or chilled or excessively bitten". With a "touch of fever", Martin took fifteen grains a day plus five grains at each major meal for a day or two, before reducing the dose to ten and five grains respectively, supplemented by aspirin.[38]

Diet and dining

Diet and health were always closely interconnected for the European missionaries, travellers and settlers in Central Africa. Tinned foods were the cornerstone of the explorer's diet, especially for those travellers, like Henry Drummond, who believed there was almost nothing in Africa that an Englishman could eat. The pioneer missionary doctors, especially Stewart, emphasised the importance of meat to the maintenance of European health in Africa. The pioneers bought fowls, eggs, goats, fish, fruits and vegetables from the locals, and largely lived on African provisions. As Europeans became more settled, they would start to hunt or grow some of their food. Milk was particularly valuable at the lakeshore, and obtaining milk became crucial for the Scott family in 1885, after all the cattle in Bandawe had died. Scott noted that goat's milk did not suit the baby, and this, together with the recuperative value of a change of air, prompted the family's move to uNgoni in early 1885.[39]

Tinned food remained an important part of the European diet until the early twentieth century. In 1901, Henderson observed that Europeans who travelled to Ngoniland could be "thankfully independent of tins", as there were plenty of herds, grain stores and game in the country. Out of necessity, many missionaries became accomplished hunters. By the early 1930s, Europeans in Nyasaland were advised to avoid tinned foods as far as possible.[40]

The importance of feeding in the nursing of patients is discussed in Chapter 5. Eggs, milk, and chicken soup were all used to restore energy and digestion. Meat, especially in the form of meat juice and extract, was an important part of the diet prescribed for patients recovering from fever attacks. In 1903, when Prentice treated the seriously ill missionary builder Murray in Kasungu, one sign of his recovery was that after Prentice had killed a bullock,

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38 Overtoun Institution Senatus Minutes 4 October 1915. MNA 47/LIM/3/32; Martin 4 August 1928. Sinclair 2002, pp. 42, 334; McIntosh 1993, pp. 195-196

39 Drummond 1888, p. 14; In this, Stewart was following the thought of Livingstone, who believed that "A considerable proportion of animal diet seems requisite" in Southern Africa. Livingstone 1857, p. 117; Scott to Laws 17 February and 29 May 1885. NLS, Acc. 9220 (1) (iii). McIntosh 1993, p. 42.

40 Henderson 9 November 1901. NLS, Acc. 7548 D 70; Murray 1932, p. 435.

Murray was able to take raw meat juice and freshly prepared meat extract. One local interpretation of this would be that the missionaries had killed a bullock in sacrifice to spirits. Elmslie recalled that this was a popular belief in Ngoniland after he had fed meat juice to Mrs Elmslie.[41]

The importance of fruits and vegetables to a healthy diet was increasingly emphasised by missionaries and in particular by Agnes Fraser, in the early twentieth century. The growing of fruits and vegetables, and keeping of cattle meant that stations such as the Institution, Loudon and Kasungu (where Prentice was very active in cattle rearing) emerged as agricultural centres in the 1910s and 1920s. The descriptions of missionary life from the early 1920s suggest that by this time, the missionaries lived and ate well. Prentice, the Frasers and Laws were all heavily involved in agricultural production. Fruits, vegetables, meat, poultry and especially products such as cream and eggs were considered to be part of a healthy diet and by their own standards the missionaries were eating in an increasingly healthier fashion, although there were occasional shortages of milk and eggs in Bandawe at least.[42]

The European eating culture, distinguished by dining table, chairs, tablecloths and the use of cutlery, separated the whites from most of the Africans, and the Protestant missionaries were keen to emphasise these differences to the converts. The use of European furniture and cutlery by Africans were seen as marks of progress. However, cultural customs, hygienic rules and ethnocentric attitudes generally prevented Europeans from sharing food with Africans at the same table and after the missionaries settled permanently, these patterns of behaviour became fixed. For Europeans, eating was a closed and private affair.[43] Mamie Martin described a young Afro-European Catholic-educated woman whom she liked, stating that one reason why she found it *"impossible to treat her quite as an equal"* was that she *"eats native food in native fashion"*.[44] Africans were keenly aware of these symbols and rituals of inequality, and one reason why Catholic missionaries were sometimes more appreciated than Protestants in Malawi was that they shared food with Africans. In her study of colonial Congo in the early twentieth century, Hunt has pointed out that for Africans, "good eating" was the generous sharing of

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41 Prentice 25 June 1903. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee, 1903, pp. 100-101; Elmslie's recollections, displayed in the Stone House Museum, Livingstonia.

42 *The Record*, February 1921, pp. 56-58. In December 1921, Mamie Martin described the prevailing missionary diet: for breakfast, porridge (wheat and maize mixture), eggs, tea, coffee, and plenty of bananas and oranges; the lunch menu included salads, puddings, tomatoes, and plenty of fruit; dinner was "always 3 course" and was followed by tea or coffee on the verandah. Meat was limited to fowls, but the variety of fowl dishes was considerable. Martin 1 December 1921 and 9 August 1922. Sinclair 2002, pp. 25, 87. At Kasungu, Prentice had "well stocked orchard and garden" which were regarded as valuable health assets. Kasungu Transfer Minutes, NLS, MS. 7886, 92.

43 On missionary tour in 1923, the Martin's servant set down the missionaries' table and chair on the konde of the "nicest house in the village" and then told the people to clear off, as "the Wazungu don't like to be watched when they are eating." Martin 9 April 1923. Sinclair 2002, p. 127.

44 Martin 23 October 1923. Sinclair 2002, p. 157.

food. In contrast, private European domesticity and in particular tinned foods aroused suspicion and were morally questionable from an African perspective. Notably, European dining could be associated with colonial surgery and cannibalism.[45]

Missionary health in the 1900s

In 1925, Laws noted that while the mortality of mission staff during the first nine years was forty per cent, for the past eighteen years there had been "no deaths due to African diseases".[46] There was no doubt that missionary health in Central Africa had greatly improved. Antimalarial measures, station buildings and diet had all improved considerably, while developed communications, transport and mobility enabled greater access to medical care and more efficient evacuation from the country.

Nevertheless, missionaries were far from immune from illness and personal or family ill-health continued to be prominent reasons for many missionary resignations or withdrawals.[47] According to Margaret Sinclair, the diary of Mamie Martin (the last European who died at Livingstonia during the period studied) between 1923 and 1928 contains "a horrifying amount about illness" among the missionaries, with hardly a week without a reference to someone being ill with fever or "biliousness".[48] However, missionary illnesses in the 1920s rarely resulted in the patient's death. A number of missionaries were sent home mid-term due to ill-health, some of whom were suffering from nervous and mental health problems.[49] The departures of many missionary doctors in the 1920s, including Innes, Elmslie, Laws and Turner, were due to their own or their wives' ill health.[50] Alexander Caseby was warned that he was "prone to malaria" by doctors and he was advised to take quinine regularly, to use mosquito nets and long mosquito boots, not to work too hard after dark and to avoid murky, humid and swampy areas. Despite these precautions, Caseby still suffered from "agonising" attacks of malaria.[51]

Missionary children, as a rule, were brought up in Scotland largely to secure their health, although many had actually been born in Africa. For the sake of their health, some missionary wives were sent home before their

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[45] George Simeon Mwase, in Rotberg (ed.) 1967, p. 65 and Linden 1974, p. 1; Hunt 1999, pp. 185-189.

[46] *The Record*, October 1925, p. 449.

[47] See, for example, Boxer 18 October 1905. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1905, p. 96.

[48] Sinclair 2002, p. 118, footnote 116. Mamie Martin died of blackwater fever in September 1928. Martin 25 September 1928. Sinclair 2002, pp. 342-343.

[49] Laws to Wilson 13 October 1924. MNA 47/LIM/1/1/24, 17; See also Sinclair 2002, p. 220. These included a female missionary who was sent home in 1924 on furlough to avoid being permanently invalided. Laws believed that "climatic conditions...have told badly on her here". A similar case of "breakdown" seems to have occurred in late 1922. Sinclair 2002, p. 93. Cf. Good 2004, p. 271.

[50] Elmslie to Ashcroft 5 May 1924. NLS, MS. 7887, 49; Martin 2 November 1922. Sinclair 2002, p. 102; McIntosh 1993, p. 188-191.

[51] AUL, MS 3289, Caseby Papers, No. 9.

husbands.[52] Missionaries suffering from physical or mental illness continued to be moved to different stations (preferably hill stations) in the 1910s and 1920s. In 1914, for example, Elmslie was worried about the health of Dr Turner, who was showing *"symptoms of mental strain as well as physical exhaustion and a tendency to melancholy"*. He recommended that to counter his melancholy Turner should be moved to a hill station along with another colleague with "a sunny temperament".[53] In 1920, Wilson believed that Prentice was so depressed that he should not be left alone on a station. In 1922, Mamie Martin believed that a move to the Institution was beneficial to the ailing Mrs Turner, both because of the cool climate and the stimulating social life.[54]

10.2 Missionaries and colonialists

Livingstonia and the British South Africa Company

Laws' connections to Cecil Rhodes went back to the late 1870s, when Rhodes' brother, Herbert, was hunting and trading in the Lake region. Eventually, it was Rhodes' British South Africa Company, which not only annexed vast areas in the west and southwest of Livingstonia, but also funded the first years of the administration of British Central Africa. The BSAC became a major landowner in the new Protectorate, and obtained the lands in the Khondowe area, which Laws had wanted for the planned Central Training Institution. He met Rhodes for the first time in 1891 and was keen to point out to Rhodes that the Institution would enhance the value of his territory in the region. Negotiations over the site took several years, but building commenced in 1894.[55]

The connections between the mission and the company therefore already existed whilst plans were being made for Livingstonia's expansion into the western "hinterland", an area that came within the company's territory. With the establishment of a medical mission in the area, the interests of the mission and the BSAC converged. In 1898, Codrington, the Deputy Administrator of Northern Rhodesia, made enquiries to find out whether Livingstonia would be receptive to the Company's proposal that it would provide an annual sum of money to cover the salary of a qualified medical missionary to be stationed by the Stevenson Road at Mwenzo (on the Tanganyika plateau). Laws replied that this was likely, on the understanding that the doctor would be a medical missionary helping Company employees in need. The Company would have preferred to pay a fixed annual sum for all the medical services rendered, but

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52 Prentice in *The Record,* April 1922, p.122. Prentice argued that a childless missionary couple would be ideal workers. Cf. Murray 1932, p. 375. Notice on the death of Dr Chisholm in 1936. Minutes of the Mission Council, August 1936. MNA 47/LIM/3/18. For births in the 1920s see, for example, Sinclair 2002, p. 205.

53 Copy of Elmslie to Laws 26 November 1914. MNA 47/LIM/1/1/14, 227.

54 Wilson to Ashcroft 30 July 1920. NLS, MS. 7885, 6; Martin 8 October 1922. Sinclair 2002, p. 95.

55 Livingstone 1921, pp. 108, 266-268. McIntosh 1993, p. 112.

Laws suggested that a sum of one hundred pounds would cover medicines and attendances for a year, and would probably be cheaper for the Company than paying fees on a case-by-case basis. However, he insisted that all medicinal alcohol should be provided by the patients themselves.[56]

However, Laws' colleagues condemned this formal plan of co-operation. Elmslie wrote to the Committee in 1899, stating that the Mission Council believed that the position of a doctor stationed at Mwenzo under the terms outlined by Laws and Codrington would be intolerable. They argued that the reputation of the BSAC agents was questionable, and agreed that no missionary should be required to render services to "outsiders" in this way. Instead, the doctors in the Council drew up a scale of fees for medical consultations and treatments. Elmslie then wrote to Codrington informing him of the fees. In 1907, the Mission Council updated a more detailed scale of fees. "Native officials" were, as a rule, charged half of the standard fee. In accordance with the mission's disapproving attitude towards "moral" diseases, venereal cases were charged "ordinary to double fees".[57]

In 1900, Chisholm settled in Mwenzo, and was able, with the help of European medical fees, to build a large station with a brick hospital within three years of his arrival. During 1901 Chisholm treated over sixty European cases, visiting them in their homes for four weeks and treating resident cases in his home for no less than eleven weeks. The Committee at home was alarmed that Chisholm's European practice would hamper his missionary work. However, in 1902 Chisholm assured them that the number of European patients was decreasing, as there was now an Administration doctor resident only four days away. However, many European travellers from the Stevenson Road stopped at the station, and so there was a steady flow of patients. Chisholm insisted that he had a duty to help his young fellow-countrymen in need of medical and moral aid, whose " *temptations are greater than can be imagined by friends at home, and it is little wonder that so many fall. They have no public opinion to restrain them (much the opposite)…"*[58] In response to the argument that the missionaries were sent out for the Africans, not for Europeans, Chisholm argued that influence over colonialists enhanced missionary influence over Africans.

In April 1903, Chisholm reported that European health in the district had been generally good, but that he currently had had two complicated cases – both requiring treatment in their homes some distance from the station. European practice had provided £30 in medical fees to the station's accounts, but Chisholm was frustrated at having to leave the station while very busy with translation and other mission work. During 1903 there were several serious

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56 Codrington to Laws 22 October 1898, Laws to Codrington 17 November 1898, Copy of Laws to Codrington 15 July 1899. NLS, Acc. 7548 D 69, Letters to the Livingstonia Sub-Committee, 1898-1900, 82, 92.

57 Elmslie to Smith 14 November 1899, Elmslie to Codrington 14 November 1899. NLS, Acc. 7548 D 69, Letters to the Livingstonia Sub-Committee, 1898-1900, 92; Minutes of the Mission Council 11 April 1907. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1907, p. 55; Appendix 5.

58 Chisholm 14 June 1902. NLS, Acc. 7548 D 70; *Annual Report for 1901*, p. 23.

"blackwater" cases, many of which proved to be fatal. For Chisholm, treating seriously or terminally ill colonists enabled him to interact as a missionary with people he would not have otherwise met.[59]

In early 1904, Codrington visited Livingstonia and discussed BSAC land policy with Laws. In North-Eastern Rhodesia, the Company charged the Mission £13 per annum for the twenty square mile area of the Mwenzo station. In the Protectorate, however, the BSAC were simply landholders, and did not charge the mission.[60] Codrington was keen to support other medical mission stations in Northern Rhodesia. In 1904, he wrote to Laws that he had reserved a portion of land near Old Chitambo, where Livingstone died, as a site for a memorial medical mission. Codrington offered this plot to Livingstonia, together with £100, *"as an inducement to start medical work at once".* Laws thanked Codrington for his offer and assured him that Livingstonia was interested in taking up the work in Chitambo.[61] Against the opinion of the Mission Council, Laws argued to the Committee in Scotland that placing a medical missionary in Chitambo was a necessity, for both mission expansion and for exerting influence upon colonialists:

> Though we may not hold ourselves responsible to give medical attendance to Europeans, there is no doubt about the influence for good a kindly, judicious, Christian Medical Missionary can exercise.[62]

For Laws, medical co-operation with the BSAC was the most successful means of securing Livingstonia's expansion into Northern Rhodesia. He also argued that for the sake of missionary health, a doctor was required in the pioneer outposts there. Eventually, a doctor was stationed at Chitambo, however the resignation of Dr Brown in 1912 left the station without a doctor until 1914, after which the war disrupted the new doctor's (Dr Wilson) work.[63]

After Wilson returned to Chitambo in 1920, he reported that numerous European and African patients had been sent to him by the Boma. Africans, mostly suffering from ulcers, were sent in a "steady stream of extemporized

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59 Chisholm 20 April and 14 July 1903. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee 1903, pp. 75-76, 106-109. By this time, Chisholm could be contacted by telegram.

60 Laws 11 January 1904. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee 1904, pp. 46-48.

61 Copy of Codrington to Laws 2 August 1904. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1905, p. 17; Laws to Codrington 28 April 1905. NLS, Acc. 7548 D 71.

62 Laws 9 August 1905. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1905, p. 79.

63 Laws 20 June 1906. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1906, pp. 97-98.African teachers and evangelists were at the forefront of Livingstonia expansion, and it was planned that they should be sent to Chitambo before the Europeans. However, the BSAC administration disapproved of sending "unsupervised natives" to its territory, and Laws had to cancel one early party. Laws continued to insist that the policy of sending "tried" Africans to prepare the ground for Europeans had merit, and stressed that Scottish missionaries would eventually settle permanently in Chitambo. Beaufort to Laws 3 June 1905; Laws to Beaufort 18 September 1905. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1905, pp. 84-87.

machilas". From Chitambo, Wilson visited Serenje Boma prison, where he inspected the sanitation, examined the prisoners and advised on their treatment during 1924 and 1925. In November 1925, the Principal Medical Officer for Northern Rhodesia proposed formal, extensive medical co-operation between the administration and the mission. The colonial administration offered medical mission stations a grant of £10 per hospital bed for African patients. In Chitambo, the grant of £120 would have covered the costs of the entire medical department. A further £40 per annum was offered in return for the free treatment of officials and their families, and the continuation of Wilson's work as a visiting doctor at Serenje prison. Further medico-legal co-operation was also proposed. Wilson held the offer to be very generous and provisionally agreed, trusting that the Mission Council would support him. He emphasised the friendly relations between Livingstonia Mission and the government, and he argued that the co-operation would be to the benefit of the African population. With the financial aid of the administration, Wilson reported in early 1926, that hospital practice was "booming" and that the station was medically self-sufficient. In the last three months of 1925, he recorded 64 in-patients, 4,040 out-patient attendances, and 5,707 vaccinations.[64]

Laws encouraged Wilson to use his medical authority to influence European colonialists. When Wilson reported that prospectors were arriving in the Chitambo area, Laws wrote that although Europeans of "this description" were often difficult neighbours for missionaries:

> you will have the whip hand of them unless they have a doctor of their own and they cannot very well offer to quarrel with you and so many people listen to your message when they would not listen to any other body's.[65]

A monopoly over medical services would give Wilson authority that he could use for moral influence among Europeans. It was easier to establish medical hegemony over a small European settler community than over an extensive African society with an established medical culture and several medical specialists. The only doctor in the district held the "whip hand", but how efficient this was in practice remains open to speculation.

10.3 Public health and epidemics

In early twentieth-century South-Central Africa, the diseases with which the British colonial authorities were most concerned included smallpox, plague, sleeping sickness and influenza. The prevention of these diseases was a major concern of the colonial medical officers, who sought co-operation with the missionaries in their public health policies.

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64 Wilson to Laws 29 September 1920, 2 November 1925, 18 January 1926. MNA 47/LIM/1/1/35.

65 Laws to Wilson 1 September 1926. MNA 47/LIM/1/1/25 (a), 645.

Smallpox

A smallpox epidemic affected the Bandawe region in 1894, at the same time as an outbreak of "kalira", a fatal animal disease (in all probability, rinderpest). Missionaries propagated for the isolation of smallpox cases, and after the death of a headman who refused to isolate his sick wife, MacAlpine recalled that the people swiftly adopted isolation measures. There was a considerable demand for vaccination, which was not an alien procedure by this time. Variolation had been practised in the region to some extent before missionary arrival and small-scale vaccination programmes had been carried out by missionaries since the 1880s at least.[66]

In 1900, Dewar reported the outbreak of a smallpox epidemic in Karonga. A "boy" living in the mission grounds had brought his wife from an infected area in the German Territory, and she apparently carried the disease. When she fell sick, her husband's friends secretly took her to the newly-built Henga village about a mile from the mission station. When the disease broke out in this village, where many Christians and catechumens lived, it was quarantined, and at least five people died.[67] In this case, smallpox was brought to the area through the actions of mission associates. As a consequence, the village of the "most faithful" mission adherents was quarantined and cut off from medical or religious services. In such a case, the mission itself could be accused of bringing the illness and failing to provide therapy for its associates. Among many Malawian societies, it was believed that the moral state of a group determined whether it would survive a smallpox epidemic.[68]

The mission doctors co-operated closely with the administration in their attempts to combat smallpox, although vaccination programmes were often hampered by spoiled supplies of lymph. In 1902, Laws sent two Livingstonia "lads" to begin vaccinations in the Senga country. In 1906 and 1907, Dr Hearsay, the medical officer at Zomba, began a new vaccination campaign, and enlisted the assistance of the mission doctors, sending them supplies of lymph.[69] In 1908, Elmslie, then in charge of the Institution, informed Dr Norris that he was interested in the vaccination scheme and could possibly provide two or three Institution pupils as junior vaccinators. Following reports of the epidemic, lymph was sent from Government stores to mission stations. Livingstonia doctors also co-operated with colonial authorities in vaccination

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66 EUL, MacAlpine Papers, MS. 3086.4; Good 2004, pp. 238-240; Herbert 1975; Lwanda 2002, pp. 65-67.

67 Dewar to Smith 17 April 1900. NLS, Acc. 7548 D 69, Letters to the Livingstonia Sub-Committee, 1898-1900.

68 Good 2004, pp. 239-240.

69 Laws to Hearsay 26 August and 9 October 1902. MNA 47/LIM/1/1/5, Overtoun Institution Letterbook 1902-1906, 179, 233; Laws to Hearsay 2 December 1906; Enclosure to Dr Hearsay, n.d. MNA 47/LIM/1/1/9, Overtoun Institution Letterbook 1906-1908, 172, 17.

programmes in Northern Rhodesia. Between October and December 1925, Wilson vaccinated 5,707 people in Chitambo.[70]

Ordering of people and space

Isolation and quarantine were (and are) public health measures that required medical practitioners either to be in a position of power or to co-operate closely with the temporal authorities. The order that people, often seriously ill individuals, be confined to a limited space away from their healthy relatives and friends, was an act of power and a rearrangement of space which required considerable authority. In Livingstonia, the immediate authority of the missionaries extended to those Africans living and working at the mission stations, notably pupils and workers. However, through the tacit co-operation of African authorities, and (from the turn of the century onwards) formal co-operation with British colonial authorities, the missionaries were able to extend the area where they could order or at least advise on isolation measures.[71]

Supervision of the mission grounds in order to prevent insect-borne diseases was essential to health. At the turn of the century, jiggers and ticks were identified as serious threats to hygiene on the mission stations. At Institution schools, regular "jigger parades" where pupils were meticulously inspected, were held. With the more effective medication against malaria, tick fever became a major concern for missionary doctors. The fear of ticks reinforced hygiene regulations and the constant supervision of cleanliness on the mission stations. In 1907, Chisholm burned some tick-infested huts in Mwenzo, hoping that this demonstration together with education about the dangers of the tick would reduce the number of cases in the hospital.[72]

The main station of Livingstonia, the Institution, was established as one of the most isolated stations from colonial centres of power. The nearest British administrator was located in Karonga.[73] The isolation of the large mission centre with hundreds of pupils and employees concentrated administrative, disciplinary and medical responsibility and authority in the hands of Laws, (and in his absence, Elmslie) as the Principal of the Institution. In their double

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70 Elmslie to Norris 3 October 1908. MNA 47/LIM/1/1/12, 111; Laws to Principal Medical Officer 16 January 1911. MNA 47/LIM/1/1/13, 182; Wilson to Laws 18 January 1926. MNA 47/LIM/1/1/35.

71 In 1927, when Livingstonia had "a little church for lepers", with five communicants, Laws wrote: *"It is very difficult to get the natives to see the advantage of segregation and to carry it out..."* Laws to Rev. Oldrieve 21 April 1927. MNA 47/LIM/1/1/25 (a), 916. For quarantine and colonial power, see Bashford 2004.

72 Chisholm 9 August 1907. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1907, pp. 93-95; Laws to Dr Hearsay (PMO, Zomba) 23 March 1912. MNA 47/LIM/1/1/13, 924; Livingstone 1921, p. 290.

73 Despite the improvement of the roads leading up to the Institution, in 1917 Laws wrote that when the condition of the road did not allow motor transport, it would take him three days to reach Karonga. Laws to Acting Chief Secretary 2 August 1917. MNA 47/LIM/1/1/14.

roles as doctors and heads of station, they controlled the mission space and arranged it according to the requirements of their ideas of hygiene.

During the smallpox epidemic of 1900, Elmslie reported that it would be impossible to quarantine the four hundred workers who every weekend left the Institution to gather food, until the mission was able to supply about four tons of food per week. Elmslie had requested a large supply of "native food" from Bandawe for such an emergency. All pupils returning from holidays on the lakeshore were quarantined upon arrival, prior to medical examination. Providing infected workers with food and paying their wages would keep them voluntarily in the segregation camps.[74] In such a situation, missionaries depended on persuasion and economic incentives, rather than compulsion, which they could not physically enforce. They had more direct power over the mission pupils, however.

In 1902, a girl pupil from Karonga was diagnosed with smallpox at the Institution. She was immediately isolated in a small, hurriedly erected hut. "A kindly native woman" moved in with the patient, while the girls' clothes and dormitory were disinfected. All the girls were quarantined for a fortnight. To the missionaries' relief, no other pupils were infected and the only patient recovered quickly.[75] In January 1911, Laws ordered that a pupil from Mwenzo who was suffering from chickenpox, as well as those who had slept next to him, be quarantined. In 1913, Laws reported the death of an isolated patient infected with chickenpox (and possibly smallpox). The isolation hut was burned and the places where the patient had been were disinfected.[76]

Sending infected patients away from the Institution was an alternative to quarantine. In 1911, Turner and Laws suspected that a printing office "lad" from Bandawe was suffering from tuberculosis. After he had been coughing and spitting in the printing office, it was decided that he was a health risk to others and that in the interests of public health he should return to Bandawe, to spend as much time as possible in the open air.[77] Sending a patient from the hills to the lakeshore to recover was in this case a reversal of conventional European treatment of tuberculosis in high-altitude sanatoriums.

Sleeping sickness campaigns

Perhaps the first doctor to diagnose sleeping sickness in the Northern Malawi region was Chisholm, who in 1907 carried out a blood film analysis in the case of a dying patient who had arrived in Mwenzo from the Congo border. The disease threatened the border area between Northern Rhodesia and the

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74 Elmslie to Smith 18 May 1900. NLS, Acc. 7548 D 69, Letters to the Livingstonia Sub-Committee, 1898-1900, 95; *Annual Report for 1901*, p. 3. Only one death was reported during this outbreak.

75 Laws 16 June 1902, Knight 3 July 1902. NLS, Acc. 7548 D 70, Letters to the Livingstonia Sub-Committee, 1902, pp. 47-49.

76 Laws to Chisholm 11 January 1911, MNA 47/LIM/1/1/13, 172; Laws to Resident, Karonga, 3 October 1913. MNA 47/LIM/1/1/15, 405.

77 Laws to MacAlpine 23 November 1911. MNA 47/LIM/1/1/13, 648.

Nyasaland Protectorate, where Livingstonia doctors were the most important group of Western practitioners. From the outset, therefore, mission doctors were in close contact with the colonial authorities about the problem of sleeping sickness. In particular, Prentice in Kasungu actively encouraged and participated in anti-sleeping sickness and anti-tsetse fly campaigns.[78] In 1907, the BSAC administration requested that Prentice temporarily replace the Medical Officer at Fort Jameson. Prentice had no doubt that *"In this fight against the entrance of sleeping sickness the Government and the Mission must unite..."*[79]

With the increasing fear of a sleeping sickness epidemic, the movement of people became a major concern for the administration in both Nyasaland and Northern Rhodesia. Stringent movement restrictions were put in place to prevent people spreading the disease. Researchers were puzzled by sleeping sickness and as there was no known cure, prevention through quaratine was deemed to be essential. The border zones adjoining sleeping sickness risk areas were closed, people were inspected and all those found to be infected were sent to segregation camps. The African associates of Livingstonia, notably teachers and pupils who moved between stations themselves became a concern. The Livingstonia doctors took an active part in the sleeping sickness campaign, being enlisted to carry out inspections. The sleeping sickness campaign was arguably sometimes more akin to military rather than medical practice.[80] In 1912, Dr Sanderson, a medical officer in Nyasaland, wrote that he had had "considerable difficulty" in getting people to submit to treatment and come to the sleeping sickness camps. According to Sanderson, there was "great objection to hypodermic syringe" and a "dread of segregation" among the African population.[81]

However, the missionaries also criticised the sleeping sickness policies of the administration, which considerably hampered the work of the mission. Prentice vigorously attacked the policy of game protection, claiming that the government was putting the lives of beasts ahead of the lives of the people. By 1910, Prentice was convinced that *Glossina morsitans* tsetse fly, not only *Glossina palpalis*, could spread sleeping sickness. He came to this conclusion after treating Noah Chiporoporo, a distinguished mission teacher who had contracted the disease in Rhodesia. Prentice treated Chiporoporo with arsenic and cinnamon, believing there had been a temporary improvement before his

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78 Prentice 8 December 1907, quoted in *FCSMR,* March 1908, p.118; *The Livingstonia News,* October 1909, p. 65; Nyasaland Protectorate, Report of Commissioner for 1912-1913, Cmd. 7050, pp. 22-23; King and King 1991, p.114; McCracken 1982, p. 105.

79 Prentice 9 May 1907. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1907, p. 69.

80 In 1911, for example, Laws inspected all those pupils who came from Mwenzo, and reported to the Resident that no cases of infection had been found. Laws to Resident, Karonga, 11 February and 28 March 1911. MNA 47/LIM/1/1/13. Letterbooks of Laws, 1910-1912, 219, 251; *The Livingstonia News,* October 1909, p. 65; Nyasaland Protectorate, Report of Commissioner for 1912-1913. Cmd. 7050, pp. 22-23. By March 1913, 126 sleeping sickness deaths had been recorded in the Protectorate. Cf. Lyons 1992.

81 *Transactions of the Society of Tropical Medicine and Hygiene, Vol. 5, No. 8,* July 1912, p. 321. At this point, atoxyl injections were used which were painful and ineffective.

eventual collapse and death. Prentice advocated the elimination of game in the tsetse areas as well as a number of economic initiatives. The expansion of cotton-growing, in particular, would, he argued, effectively stop the spread of the tsetse fly.[82] In 1915 free shooting-zones were temporarily introduced, but this only scattered the game, spreading the tsetse in the process. In Nyasaland sleeping sickness never became the disastrous epidemic that was experienced in Uganda or the Belgian Congo. However, in the north and north-west of the Protectorate sleeping sickness was a real concern for the medical authorities and was a source of considerable inconvenience and annoyance to both missionaries and Africans in their movement and work.[83]

Hygiene education in the Institution

By the 1920s, Innes and Laws had begun to teach health and hygiene to Institution pupils, especially to teachers and evangelists. From December 1912 to February 1913, for example, Innes taught an elementary course on hygiene and sanitation**.** Instruction was given in the vernacular, and the course included anatomy and physiology,

> taught by means of articulated skeleton, various demonstrations, and the microscope. The commonest diseases, itch, dysentery, yaws & c. are briefly dealt with from the point of view of causation and symptomatology, with a few words added as to rational treatment, and special emphasis is laid on prevention. The importance of strict personal hygienic habits is shown throughout. Various parasites are exhibited…e.g. tapeworm, ankylostome &c. Malaria is dealt with at more length, mosquitoes being hatched out from the egg, and their role as carriers fully explained. Lantern slides have occasionally been used…Questions are sometimes invited and discussions allowed...Superstitious beliefs and practices are tried in the light of modern scientific knowledge to their serious disadvantage.[84]

The pupils were also instructed in how to choose a site for a house or a village, secure a water supply and build a house following "hygienic principles". Special instruction was given on infant feeding and care. The teachers and evangelists were to disseminate the hygienic message in their villages. Thus, hygiene was part and parcel of the Livingstonia programme of holistic regeneration. When the teachers left the Institution, they were given an illustrated card of "the danger of the mosquito", which was intended to arouse the interest of adults in their villages. They also received copies of the Protectorate sanitary regulations so that they could explain the reasons for and

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82 In 1920, Laws wrote to Prentice that sleeping sickness regulations and movement restrictions were "a great nuisance", and that effective cross-border control between Nyasaland and Northern Rhodesia was impossible, although he held that the regulations were, to some degree, necessary. Laws to Prentice 6 October 1920. MNA 47 LIM/1/1/19, 859; *Annual Report for 1910*, pp. 27-29; *The Livingstonia News*, August 1910, pp. 63-66 and October 1910, pp. 73-74.

83 *The Livingstonia News*, October 1911, pp. 80-81; McCracken 1982, p. 107. Cf. Good 2004, p. 251.

84 Innes, "Report of Teaching of Elementary Hygiene at the Overtoun Institution" 9 May 1914. MNA 47/LIM/1/1/15, 740.

the benefits of obeying these rules. Other mission doctors and nurses elsewhere in Livingstonia had also been engaged in similar health education initiatives. The care of infants received special attention from the 1910s, by when "terrible infant mortality" had become a major concern among missionaries.[85]

In 1925, following Dr Thomas Jesse Jones' report on education in Africa, Laws was quick to point out that the teaching of hygiene, emphasised by Jones, had been part of the Livingstonia curriculum for teachers for a number of years. At this time:

> St. 5 pupils get an hour once a week , the first session being devoted to elementary anatomy and the second to physiology; then the normal teachers get also an hour weekly which is devoted, the first session to general hygiene and the second session to common diseases of the country their causes, how to avoid them, and some notion of how to treat ordinary cases. Along with this, in both classes, instruction in first aid is given in the case of wounds or accident.[86]

During the first decades of the twentieth century, many of the newly identified "tropical" diseases had no specific, efficient cures, which led to the Livingstonia doctors emphasising the importance of preventive medicine and public health. Innes, for example, was convinced that both hookworm and bilharziasis could be prevented with effective legislation and control of village latrines and water supplies, and actively campaigned for these measures. Hookworm became one of the main medical concerns of the missionaries in the 1920s. Lessons in hygiene for mission teachers and pupils aimed to prevent disease, as well as enforce the compulsory use of latrines. In 1929 at Bandawe, Dr Burnett threatened to close any school that would not obey him in matters of hygiene.[87] Teachers were told to co-operate with the authorities in matters of public health, above all by advocating, propagating and explaining public health measures and policies in the villages. Hygiene education fulfilled a hegemonic function in the training of African educated elite as part of the missionary programme of holistic social reform. The aim was to realise and extend missionary and colonial public health policies in the villages.[88] Case studies of the plague emergency of 1917 and the influenza pandemic of 1919 provide further insights into the role of mission teachers in public health initiatives.

Plague emergency, 1917

In December 1916, Innes received a telegram in Florence Bay from Saulos Nyirenda and Yafet Gondwe, two Livingstonia graduates and elders from the village of Mchenga near Karonga: *"We are dying our village investigate come immediately."* Laws reported to the Resident that three deaths were known of, to date. The children of three Christians, aged between six and twelve, had died

85 Laws to Chief Secretary 9 May 1914. MNA 47/LIM/1/1/15, 743.

86 Laws to Fell 4 February 1925. MNA 47/LIM/1/25, 217.

87 *The Livingstonia News,* April 1912, pp. 29-30; June 1912, p. 41; *Reports on Foreign Mission* 1928, p. 99; *Reports on Foreign Missions* 1929, p. 49.

88 See Engels and Marks 1994; Arnold 1994; Vaughan 1994b.

suddenly. The symptoms had included headache and pain in the throat. Laws requested that the Resident investigate, and suggested three possible causes: *"pneumonia of a very acute type supervening upon malaria"*, accidental poisoning from eating unprepared cassava root, or intentional poisoning. Laws suggested that Innes could send his assistant up to take blood slides in the village or, if necessary, come himself to investigate. It is significant that Laws suspected that the cause of sudden death of children in Christian families could be poisoning, although this appears to have been the least probable explanation. Eventually, Innes went to the village and after obtaining a microscope, identified the plague bacillus. His diagnosis was officially confirmed by mid-March after the medical officer had been sent by the administration to provide a second opinion. Prentice diagnosed more cases in Mwaya, and although no cases were found more than two miles south of Karonga, a widespread plague emergency ensued.[89]

The Institution was put on a state of plague alert in February. Laws ordered the wholesale destruction of rats in the neighbourhood. School and dormitory rooms were sprayed, brick house floors were scraped, and the walls were whitewashed until the lime gave out.[90] The authorities ordered that no Africans should to be allowed to travel by ship out of the North Nyasa district. Europeans could land at Vua or Florence Bay only with a valid medical certificate. Laws was asked by the worried Resident at Mzimba, whether all letters should be disinfected by steaming, a measure which Laws dismissed. However, he believed that traffic over the Rukuru River should be strictly controlled. Laws advocated not only the destruction of rats, but used the opportunity to attempt to generate a "terror" of lice, flea, bugs and "all biting creatures" among the African population. The deadliness of the disease was seen as a good way to advertise the importance of cleanliness: *"75% of a death rate is something to stir them* [the Africans] *up a bit."* Laws called upon the people and headmen of the villages surrounding the Institution, *"to exterminate rats where ever found, to have all dogs and cats washed with the juice of fish poison, or destroyed. Also to have a general war against all the vermin especially the fleas of the rat, dog and cat, the first being the worst carrier."* Laws suspected that this programme would be only partially adopted by the headmen and people, but believed that they had taken the warning seriously. He was asked, *"if in the case of plague breaking out patients could not be removed from their villages to a central Hosp. for treatment. Of course I told them this was the very thing we wished them to help us to do."*[91] Concerns about the rules governing the removal of people to the hospital has to be seen in the context of colonial law enforcement in the area, as discussed below.

89 Laws to Resident, Karonga, 18 December 1916; Laws to Wheeler 16 February 1917; Laws to MacDonald 14 March 1917. MNA 47/LIM/1/1/17, 722, 847, 906.

90 Laws to Innes 19 February 1917. MNA 47/LIM/1/1/17, 850.

91 Laws to MacDonald 19 February and 14 March 1917. MNA 47/LIM/1/1/17, 853, 906. Rat destruction campaigns were common colonial methods of combating plague epidemics. See Vaughan 1991, pp. 39-43.

The Livingstonia teachers spread the message about anti-plague measures to the villages. Laws believed that, generally, people were responding more favourably to this emergency than they had to previous emergencies. He believed that this was largely due to the success of hygiene instruction in the mission schools.[92] To help the authorities in the continuing rat-extermination campaign in 1919, all the cats at the Institution were sent out to villages to hunt rats. However, Laws by this time argued that since it had been possible to make "good wages" through rat-killing, the people were not willing to do it for *pro bono publico* and refused to participate without pay.[93]

Influenza pandemic

Despite the concern of the colonial and mission doctors, neither sleeping sickness nor the plague materialised as a widespread epidemic in the Northern Nyasaland. Arguably, for the local population, the aggressive campaigns against these diseases must have often appeared bizarre and provoked resentment. The devastating influenza pandemic of 1918–19, in contrast, was undisputedly a deadly general epidemic. In January 1919, Laws reported on the measures being taken against influenza at the Institution to the Acting Chief Secretary. After receiving reports of the virulent epidemic in occupied German territory, Laws rearranged the Institution in order to provide more in-patient accommodation. As the grass on the plateau had already been burned, there was no available building material for temporary isolation hospitals. The schoolrooms were made into makeshift dormitories for the pupils and apprentices and the two dormitories were turned into wards. These dormitories had a khang heating, making them *"most serviceable in pneumonia cases"*. Two nurses were posted in the dormitories, with orderlies brought in to assist them. Medicines were distributed to the teachers and trusted mission associates in the more distant villages, and orderlies were sent to visit the sick in the neighbouring villages.[94]

By 24 January, Laws had recorded seventy-eight influenza cases in the neighbouring villages, of which twenty-six had died, and telegraphed this information to the medical officer at Karonga. Laws, however, stressed that these figures did not accurately represent the mortality rates in the villages, as although deaths were usually reported quickly, he had difficulty in obtaining details of the numbers of people who were or had been ill. Laws believed that all the known cases could be traced back to their sources of infection. He argued that the high mortality rate could be partly explained by the prevalence of

92 Laws to Hearsay 28 March 1917. MNA 47/LIM/1/1/17, 927.

93 Laws to Resident, Karonga, 9 September 1919; Laws to Hearsay 16 October 1919. MNA 47/LIM/1/1/19, 231, 292. The rat-hunters, often young boys, had found the business very profitable. Vaughan 1991, p. 42.

94 Laws to Acting Chief Secretary 24 January 1919. MNA 47 LIM/1/1/18, 32; Laws to Resident, Karonga, 15 April 1919. MNA 47/LIM/1/1/19, 22. Laws sent medicines repeatedly to Chikurumayemba's village and also to Mlowe on the lake shore.

anklystomes in the area. He believed that anklystomes had resulted in a general decline in health and lowered resistance to disease, especially in children, among whom influenza was most deadly. Laws appealed to the Secretary that after the epidemic had passed, and more normal conditions resumed in the Protectorate,

> sanitary regulations such as those passed by Dr Eldred at Karonga may be enforced, and that some one in a place like this should be empowered to fine or otherwise enforce sanitary regulations as it is impossible to take each offender to Karonga for trial.[95]

Thus, Laws used the opportunity to present the case for more extensive powers to enforce sanitary regulations on the plateau. For Laws, epidemics (notwithstanding the illness and death they caused) served an important function in "teaching lessons" to missionaries, Africans and the colonial administration. Epidemics particularly punished those who had ignored or not complied with the missionary rules of hygiene, and legitimised the enforcement of public health measures by those who had the knowledge and responsibility, the missionary and colonial doctors. However, the exact methods and policies of public health enforcement and control were a potential area of conflict between missionaries and the administration. In April 1919, Laws wrote to the medical officer in Karonga, criticising the new plague quarantine orders while praising African co-operation against influenza:

> The natives have responded in a wonderful way to the call to keep the "flu" out, but they will not be got to see any necessity for this and are likely to resent it and I do not wonder. They are beginning to get tired of these restrictions.[96]

Laws held that the new quarantine measures, which required that all Africans leaving the North Nyasa district had to have a medical certificate from the medical officer in Karonga, would hamper the doctors' ability to help those people in real need, as well as everyday missionary work. He demanded that the qualified doctors of Livingstonia should be allowed to issue such a pass, as they had done previously.[97] By April 1919, there had been more than 1,400 deaths in the North Nyasa district. In the New Langenburg province in the former German territory, over 30,000 deaths were reported. Many teachers and evangelists from Livingstonia died. Combined with the ravages of the war and famine, the pandemic delivered a serious blow to the whole region including the mission.[98]

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95 Laws to Acting Chief Secretary 24 January 1919. MNA 47 LIM/1/1/18, 32.

96 Laws to Arbuckle 15 April 1919. MNA 47/LIM/1/1/19, 23.

97 Laws to Arbuckle 21 May 1919; The administration agreed to this, as a year later Laws issued passes to the crew of the mission boat. Laws to Sanderson 27 April 1920. MNA 47/LIM/1/1/19, 79, 592.

98 Laws to Ashcroft 18 April, 4 and 10 June 1919; Laws to Wilson 24 April 1919. MNA 47 LIM/1/1/18, 42, 53, 55.

10.4 Law, order and medicine – public health and colonial power

Enforcement of health in the Institution

In March 1917, a "suspicious case", a patient with swollen glands, was brought to the Institution. Laws suspected that he had contracted the plague and ensured that the patient was segregated in the hospital building. However, he left the Institution against orders that he remain in hospital. The patient returned the next day after Laws had threatened to inform the Resident of his departure. The patient was admitted to the hospital and as he seemed to improve, the doctors' fears of plague subsided. The case, however, prompted Laws to request some clarification of his powers to arrest or detain patients under such circumstances.[99] The issue of the enforcement of public and private health was particularly acute at the Institution.

In the 1910s, the Institution was, in theory, within reach of colonial law enforcement at Karonga, but Laws continued to play a prominent role in ordering discipline and meting out punishment within the Institution. Laws sent the most serious offenders to the Resident. The Resident, in turn, could send police to the Institution. Livingstonia also provided medical aid to colonial employees in Karonga and elsewhere.[100]

In March 1911, Laws required the Resident's assistance. Laws had visited the village of Fulirwa where a wounded leopard had mauled two men. Laws asked for the injured men to be carried up to the hospital. This, however, resulted in a conflict with the locals:

> Two chiefs came to say all the men except three refused to help unless paid. I do not know whether I went beyond what you would have sanctioned but I advised the chiefs to write down the names of those who refused & send them to you. They replied the people had gone off to their gardens. I sent two of our machila men to help. Both patients had septic poisoning...one of very severe nature.[101]

Laws added that two leopards had been killed with gun traps within a fortnight, and that the chief at Fulirwa had "two nice skins" for the Resident. The Resident responded swiftly, ordering that the named men be sent to Laws for a period of forced labour as a punishment for their refusal to carry the wounded men. Laws was delighted, regardless of the fact that of the ten men originally condemned, three remained in their village due to sickness, and that the chief had sent ten more men, who apparently had nothing to do with the incident. Thus, in all seventeen men were sent to Laws, who set them "to work for the good of the hospital". They were employed from Monday morning to Saturday afternoon in carrying firewood for the hospital kitchen. Laws thanked Resident Storrs:

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99 Laws to Resident, Karonga, 21 March 1917. MNA 47/LIM/1/1/17, 924.
100 Laws to Resident, Karonga, 2, 8 and 15 February 1911. MNA 47/LIM/1/1/13, 200, 204, 218.
101 Laws to Storrs (Resident, Karonga) 1 March 1911. MNA 47/LIM/1/1/13, 228.

> I congratulate you on having given a most useful & salutary lesson in helping the sick by this means which will not be lost in the future. Many a life might have been saved by timely help, which has otherwise been lost.
> The man who got his hand hurt is better and home. The other, whose knee was injured, I have no hope of recovering though he may last two or three weeks yet....I offered to amputate the leg more than a fortnight ago but he refused to allow it to be done.[102]

This case was a significant example of colonial co-operation between missionary and administrator in action. The Resident provided Laws with the authority to establish his hospital as a site for medical treatment where the injured would be taken by force, if necessary. The fact that the punishment was communal and that the badly-wounded patient refused to consent to the amputation made little difference to Laws. In return, the Resident received two leopard skins.[103]

A similar case occurred in late 1916. This time, the Resident had sent a man whose arm had been mauled by a crocodile in Karonga to the Hospital, but the patient was apparently deserted by the man (or men) who had been ordered to escort him. An escort was caught and punished, and Laws wrote that: *"If the punishment of any man ever gave me satisfaction it is your giving it to the man who deserted the patient you sent"*. Again, the patient initially refused to consent to the amputation of his arm. Two days later, he agreed to the amputation, but Laws feared that the operation had been performed too late. He believed that if the man had been taken to the hospital in time, both his arm and life could have been saved. The patient died within a week.[104]

Although Laws believed that the Fulirwa incident had a "salutary influence", this display of colonial power to enforce attendance at the DGMH was not particularly successful, if measured by in-patient attendance figures. Previously it has been noted that inpatient attendances at the hospital dropped considerably in the 1910s in comparison to the earlier years of the century.[105] It seems that the alien hospital, which patients and their carriers found so difficult to reach, was resented by the villagers in the area. People refused to carry the wounded there without payment, and patients would frequently refuse to consent to amputations. As a result of the Fulirwa case, especially if the patient died as Laws had predicted, the reputation of the hospital was more likely to be dented than enhanced by the disciplinary measures taken by Laws and the Resident. However, such a co-ordinated use of force undoubtedly identified Laws and Resident Storrs closely with one another, and probably confirmed the status of Laws as a colonial authority in local interpretations, and this seems to have alienated people from the hospital to some extent.

In 1914, a disobedient apprentice, A.L., had threatened a "housefather" at the Institution with a spear, following an argument. This resulted in his

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[102] Laws to Storrs 22 March 1911. MNA 47/LIM/1/1/13, 247.
[103] Laws to Storrs 29 March 1911. MNA 47/LIM/1/1/13, 256.
[104] Laws to Resident, Karonga, 27 December 1916; Laws to Cole 3 January 1917; Laws to Chisholm 3 January 1917. MNA 47/LIM/1/1/17, 738, 752, 755.
[105] See Chapters 4 and 9; Rennick 2003, p. 231.

dismissal and the apprentice was sent to the Resident in Karonga. Laws suspected that there was a "mental twist" to the case, and wrote that he had tried to "overcome" it, but in the circumstances he had felt compelled to report to the Resident that the apprentice had exhibited a *"determined evil temper & resistance to authority leading to threats & perhaps deeds of a serious nature."* In this case, mental disorder may have been deemed to be a mitigating factor which could explain his violent behaviour. A.L. subsequently returned to the Institution but in 1916, he tried to attack a missionary with a hatchet. Laws reported that A.L. had been "more than once insane" and had shown "homicidal" tendencies, and had been sent to the asylum in Zomba with two escorts. Although Laws and Innes could not actually certify the man as insane, they stated that he had suffered previously from "acute mania" and that his "mental control" might give away at any time. The man was a "Eurafrican" apprentice, whose physical threats and challenge to the authority of the missionaries and African "housefathers" was intolerable behaviour that was pathologised as madness.[106]

Laws kept the Resident informed of patients who were treated as a result of violent accidents or actual violence. In 1907, he treated a woman, G.M., brought from Port Stewart to the hospital after she had been reportedly assaulted and raped by "Z.M". On the Resident's request, Laws gave a detailed description of her injuries, and her testimony of the crime.[107] Laws, in 1914, provided the Resident with details about a case in which a man who had died in the hospital as a result of a spear wound to the abdomen. In this case, Laws stated that he believed that the case was the result of an accident.[108] Laws also advised other mission medical staff to inform the authorities of any suspicious injuries that they treated. In 1925, Nurse Cole wrote to Laws about a boy with "bad burns" who was under treatment at Loudon hospital. According to the boy, his father and cousin had poured boiling water over him as an ordeal. If this was true, Laws wrote, then the case ought to be reported to the Boma immediately.[109]

Laws could authorise the movement or removal of people residing within the vast Livingstonia estate, either in co-operation with the colonial authorities, or on his own account. In October 1914, a group of Ngonde led by Mwakalima, who had settled on the Livingstonia plateau, complained that they were not satisfied with the location, and wanted to move to a site north of the Hara River. Many of them, especially the elderly, were sick, which Laws attributed mainly to "their own dilatoriness". Laws wrote to the Resident about the matter

106 Laws to Resident, Karonga, 20 April 1914. MNA 47/LIM/1/1/15, 690; Laws to Prentice and Fraser 23 July 1916; Laws to District Resident, Karonga, 12 July 1916. MNA 47/LIM/1/1/17, 457, 469.

107 Laws to District Resident, Karonga, 27 April 1907. "Report of the case of G.N." MNA 47/LIM/1/1/9, 247-250.

108 Laws to Resident, Karonga, 21 October 1914. MNA 47/LIM/1/1/16, 69.

109 Laws to Cole 1 April 1925. MNA 47/LIM/1/24, 328.

but, as he received no reply, he sanctioned the move, chiefly on medical grounds.[110]

After the war, Laws' authority seemed to diminish somewhat. The British colonial authorities did not apparently approve of all of Laws' ideas about acting as a temporal authority on medical grounds, and Laws was acutely aware of the lack of enforcement of sanitary regulations. In 1926, in a letter to the medical officer at Zomba, he stressed that neither he personally nor any of his staff had any desire *"to act the part of the magistrate or to inflict punishment. I was only too glad to be relieved of all such by the advent of the Government."* However, he failed to see how a sanitary offence could be punished by a magistrate months after the crime, *"especially if the offended is a passerby who is likely to give a false name, be miles away in a day or two's time"* He believed he had sufficient authority to deal with "resident offenders" under the existing arrangements.[111]

Consultation and conflicts

A central form of co-operation between missionaries and the colonial administration was the sharing of information. The missionary doctors were approached by the medical officers of the protectorate, who enquired about the medical education at the mission, the African population, general health issues and the prevalence of diseases or symptoms. In 1912, Laws responded to an enquiry from the Principal Medical Officer, stating that although he could not give the exact percentage of Institution pupils with an enlarged spleen, he had noted that most of these pupils came from villages near the mouths of the Rumphi and Rukuru rivers.[112] In 1914, on the government's request, Laws sent out written enquiries about the prevalence of leprosy in the district to other mission doctors.[113] Thus, the missionaries contributed to official colonial medical discourses about African people and localities, charting, assessing and measuring health, illness and susceptibility to disease.

The administration, being short of medical officers, wanted to use the medical professionals of Livingstonia as supplementary medical experts, who could be called upon not only to enforce public health measures, but also as specialists conducting post mortem examinations at the request of the authorities. Laws discussed the issue of post-mortems with Dr Stannus in October 1917. He was concerned that in cases of suspected murder, the Magistrates could call upon the doctors not only to perform an autopsy, but to actually exhume the body. Stannus assured Laws that the doctors, missionaries as well as officials, should refuse any such orders and demand that the corpses be brought to them. This was a great relief to Laws, who believed that, as the

110 Laws to Resident, Karonga, 23 October and 4 November 1914. MNA 47 LIM/1/1/16, 81, 96.
111 Laws to Dr Whitehead, Zomba, 20 February 1926. MNA 47/LIM/1/1/25 (a), 391.
112 Laws to Dr Hearsay (PMO, Zomba) 23 March 1912. MNA 47/LIM/1/1/13, 924.
113 Laws to Hearsay 9 May 1914. MNA 47/LIM/1/1/15, 744.

Magistrate had to be fairly sure of the case for murder and to have seen the body before ordering a post-mortem examination, there would be no need for doctors to be present at sites where bodies were found, thus removing the strain of travel to the crime scene.[114] In all probability Stannus (an amateur ethnographer) was, like Laws, aware of the perceived connections between corpses, witchcraft and cannibalism in local culture, and both men would have been keen to avoid any explicit association between white doctors and gravediggers. In early 1920, Laws wrote to Meredith Sanderson, another doctor-ethnographer, that he had performed only few post mortems because of "native prejudice" against them. However, in the Karonga area, the Ngonde sometimes performed autopsies themselves, and were more tolerant of the procedure.[115]

Although Laws was not keen to become a formal medical investigator for the colonial police, he was eager to inform the authorities of any suspected "foul play". In 1920, Nurse Mary Patrick from Bandawe wrote to Laws of the death of Kenan Amatanga in the mission hospital. From Patrick's description, Laws suspected that Amatanga had been poisoned, and advised Patrick to inform the Resident at Chintheche Boma. Laws mentioned two possible poisons that could have been administered, *"chilidu"* and crocodile bile. Although he doubted that the Resident would be able to identify the poison or actually solve the case, Laws hoped that the investigation itself might deter possible poisoners in the future.[116]

Nurse Patrick informed the Resident who, in turn, wrote to Laws requesting more information about the possible poisons that could have been used. Laws had to admit that he had actually very little definite knowledge about the case, which he had not seen, or indeed about the poisons in the region in general. Apart from the two mentioned in his letter to Patrick, the local poisons were not well known, and Laws had not, in fact, ever dealt with a poisoning case such as that described by Patrick. He had apparently been told about the poisons used in Bandawe area by the Tonga associates of the mission (who included Yuriah Chirwa, E.B. Manda and Yoram Nkata). Laws wanted the Resident to investigate with a show of force not so much to solve the case as to prevent the people from starting "*proceedings which long ago were by no means uncommon.*", i.e. witch-finding and –eradication.[117]

Unofficially, Laws wanted the mission medical specialists to offer assistance to the colonial authorities in the investigation of poisoning cases. The connections between poison and witchcraft will be discussed in more depth in the next chapter. It is significant that by becoming a poisoning investigator, a medical expert became, in theory, the colonial equivalent of witchcraft detector. Laws wanted to replace local witchcraft investigation with a colonial investigation, regardless of the fact that the doctors and the colonial police

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114 Laws to Turner 20 October 1917. MNA 47/LIM/1/1/14, 411.

115 Laws to Sanderson 29 January 1920. MNA 47/LIM/1/1/19, 450. Laws reported having performed a post-mortem on the child of a mission teacher in Karonga because it was an exceptional case which resembled lymphadenoma.

116 Laws to Patrick 6 October 1920. MNA 47 LIM/1/1/19, 858.

117 Laws to Resident, Chintheche, 19 October 1920. MNA 47 LIM/1/1/19, 882.

lacked the means for the proper, scientific investigation of poisoning. In 1927, even the DGMH still lacked the necessary laboratory equipment to conduct an autopsy with an analysis of stomach contents.[118] It was important, in principle, to create a new form and ritual of investigation even though it lacked scientific substance.

An important form of medical co-operation between the missions and the government was the establishment of leper colonies. In the early 1920s, a new treatment – injections of hydnocarpus oil derivatives - had been developed, and the British Empire Leprosy Association was formed to support the treatment of the disease in the colonies. From 1927, the Association and the government began to provide grants to mission leper colonies in Nyasaland, and one of the largest colonies was established at Bandawe. At the Institution, an early "leper village" was erected during the early 1920s, under the supervision of Alexander Caseby and his wife. According to Caseby, *"A prominent African Christian, once an evangelist, now a leper, took charge of the colony."* Beer and tobacco were prohibited in this community, which at first housed ten people. In 1924, ten pounds was sufficient to feed the sixteen patients of the colony for a year. The "Mentally deranged" and "deformed" were also sent to this colony along with lepers.[119]

Strained relationships during the First World War

The war placed the medical co-operation between Livingstonia and the colonial authorities under considerable strain. In 1917, Laws criticised the government for failing to make even one medical officer available for civilian duty, and recruiting mission doctors to the large medical department serving the small armed force. Later the same year, the mission and the administration were once again at loggerheads over payment for Innes' services during the plague outbreak in Karonga. When presented with a bill of sixty guineas, the Acting Chief Secretary expressed surprise at the charges as the anti-plague measures were obviously taken primarily in the interests of the mission.[120] This provoked a lengthy response from Laws, who sharply criticised the government's attitude towards missionary doctors, their services, and the treatment of Africans in colonial military service.

In theory, it was a criminal offence to refuse to assist the authorities, but in the Legislative Council Laws had secured an assurance that "reasonable refusal" would be accepted. On this basis Laws, who had many seriously ill patients at the DGMH, had chosen not to attend an execution at Karonga and to perform the subsequent autopsy. Furthermore, he pointed out that the authorities offered a missionary doctor considerably less pay for their services

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118 Laws to Resident, Karonga, 4 April 1927. MNA 47/LIM/1/1/25 (a), 886.

119 AUL, MS 3289, Caseby Papers, Nos. 5, 26; Good 2004, pp. 337-345; Iliffe 1984, p. 257.

120 Laws to Wheeler 16 February 1917; Laws to Stuart 2 April 1917. MNA 47/LIM/1/1/17, 847, 942; Copy of Wheeler to Laws 23 June 1917. MNA 47/LIM/1/1/14, 383.

than for the Government medical officers. Laws pointed out the extent of the medical service that the missionaries had provided without charge during the war to both Europeans and Africans engaged in military service.[121]

Laws also highlighted the fact that the missionaries had treated several Africans who had been discharged from war service at Karonga, sick and *"unable for a journey home and with inadequate provision for their food by the way."* Some died, while others were found by locals and brought to the DGMH. Laws had charged the administration for only two of these patients, who had been en route to Mzimba, according to the pre-war rates paid by the Rhodesian administration to Mwenzo hospital. One of these was a *"chronic case whose treatment lasted many weeks and included operation under chloroform."* The other patient died. The Resident at Mzimba informed Laws that the administration could pay for a maximum of only fourteen days of in-patient hospital treatment for Africans. Laws was later informed that according to the Director of Medical Services, the "maximum charge for any one native allowed" in a hospital was £1 1s and that this was the sum that the mission was entitled to. Laws described another "war case" in some detail. A man from Bandawe was *"commandeered for the war work"*, despite being under medical treatment. He was taken to Wiedhafen, and was soon hospitalised with dysentery. Eventually, he was put on a steamer and landed at Vua alone and seriously ill:

> He managed to drag himself from Vua to Mlowe passing over forty haemorrhagic stools daily. At Mlowe his strength failed him and some men put him in a canoe and brought him to Florence Bay. I heard of his arrival by telephone and got him brought to here to the hospital by machila. He was in the hospital fifty-one days when his friends brought a canoe from Bandawe to take him home. I did not consider him even then as being able to leave the hospital but had no power to detain him. He died since then.[122]

Laws ended his letter with an uncharacteristically scathing critique of the administration's treatment of sick Africans in military service, and the general unwillingness to compensate the mission for their medical services:

> Now it strikes me that a question put in the House of Commons as to there being a Rule that a native suffering from the result of war service if not better in fourteen days he must be turned out of hospital, or if the expense of his keep and treatment reached a guinea then he must be left to perish would be an exceedingly awkward one for the Government here to answer. I should like also to point out as regards cost of treatment...that, before the war, drugs cost at Blantyre 70% on home prices, while here they cost us from 125 to 175% on home prices and bulky dressings were very much higher, a point which makes a great difference in the cost of treating the chronic ulcers which were so frequent among the carriers at the war.[123]

In this letter, Laws recognised in passing the help rendered to the sick carriers by the local African population, who carried them to the hospital. The conscription of Africans into the transport service continued until 1918. In

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121 Laws to Acting Chief Secretary 2 August 1917. MNA 47/LIM/1/1/14.

122 Ibid.

123 Ibid. Some thirty per cent of African male population in the Protectorate were recruited or forced into military service, most served as carriers. McIntosh 1993, 180.

February, Laws wrote to Colonel Duff at New Langenburg, that there had been a "frightful mortality" among the carriers, who included many Livingstonia teachers. Several had died and many more had *"reached their homes as living skeletons"*.[124] The war prompted the missionaries to privately criticise the attitudes and policies of the British towards Africans in the colonial military service. As doctors, the missionaries saw the results of neglect, but publicly the mission, which had fully co-operated with the authorities in the recruitment of carriers,[125] remained quiet and loyal.

10.5 A critique of colonialism? European morality and health

The early missionaries identified a number of degenerative European influences in Africa, notably sexual liaisons which resulted in the spread of venereal disease, and liquor traffic. Although the decision to locate the Institution in the remote highlands was largely due to the need for a European sanatorium, the distance from the centres of European influence was also important, although Laws believed that mission stations on the lake were useful in checking "European vice". In late 1891, Laws met Harry Johnston and expressed his "dread" of the colonial occupation, because of the "evils" it would introduce. Furthermore, Laws feared the effect of occupation on the "mind of the natives" who had become, in his opinion, accustomed to regarding Europeans as "supreme beings". He demanded that the administration should have a "high moral tone". Having seen Blantyre in 1891 Laws was convinced that the Institution should be located far from centres of European occupation.[126]

Laws' authoritative status as the oldest and most experienced mission leader and doctor in the Nyasaland Protectorate and as the member of the Legislative Council between 1913 and 1916 enabled him to discuss issues of health and morality with the highest authorities of the Protectorate. In early 1912, Laws replied to a lengthy letter from the Governor, discussing issues of labour migration, health and morality. Laws agreed with the Governor that for both economic and health reasons, there was a need to keep African workers within Nyasaland. Apart from the notoriously high death rate in the south, Laws stressed that a "considerable number" of migrant workers returned home infected with tuberculosis. Laws also believed that South Africa, where there were "no moral or religious restraints", was a physical and moral trial to migrant workers, and that few of them returned from there "unscathed" although those who did were "better and stronger men". He was, however, even more worried about people going to Elisabethville in the Congo.

Laws was particularly pleased that the Governor was concerned about sexual morality and health, and especially prostitution. Laws argued that

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124 Laws to Duff 21 February 1918. MNA 47/LIM/1/1/14, 452.

125 McCracken 2000, pp. 269-270.

126 Livingstone 1921, pp. 253-258. On drinking and sexual promiscuity among the European colonialists in the 1890s, see Jenkins 1990.

Nkhotakhota was a *"fruitful source of such immorality"* – a number of women from Nkhotakhota had travelled south to work as prostitutes – and that he had heard that "touts" from South African brothels were recruiting women in Nyasaland. The Governor was particularly worried about the possibility of African men visiting European prostitutes. Laws also reported that he had heard from a European source that *"when Central African Rifles were going to Mauritius, one of the solaces used to calm the discontent of some at leaving their wives was that at the Mauritius they would get white women with whom they could cohabit"*, but had kept the scandalous matter secret. Laws thanked the Governor for prohibiting the sale of "indecent photographs", adding that unfortunately *"not a few of our natives had seen such and I think some had even bought them."* The Governor's greatest fear was obviously that pornography and prostitution, especially European prostitution, could lead to the rape of white women. Laws addressed the issue at length:

> As to the rape, or intended rape of white women by natives, such can only be thought of in horror, but teaches its own salutary though terrible lesson. We see these things in their appallingness in South Africa, largely because of their concentration, but any day we may be face to face with...them in here, and hence I feel it necessary to refer to the causes leading to what is so deplorable in South Africa. As a Medical Missionary I can do so with more knowledge and experience...at the bottom of all sexual immorality lies sexual desire and the lack of self control which leads to its illegitimate exercise. This is true enough statement, but when the circumstances of such illegitimate actions are looked into and the ramifications from the attendant results are traced, then its awfulness becomes apparent.[127]

Laws believed that at the heart of the problem in South Africa, was a culture of disrespect towards African women, which was especially evident in the behaviour of white men. He argued that there was no "even handed justice" when African women were not protected from white rape, while whites could murder Africans in cold blood on the mere suspicion of interracial sexual relations. This in turn caused resentment among Africans, and as a result, *"their feelings are apt to find vent in outbursts of resentment, or even, when evil passions are appealed to in the ways indicated in your letter, by outrages in which Whites have shown the example."* As an authority on medicine, Laws argued that African sexual desire and lack of self-control combined with resentment of European sexual behaviour and stimulation from pornography and prostitution could lead to interracial rape, although this had not yet occurred in Nyasaland. He stressed that the responsibility to check these dangers ultimately lay with Europeans.[128]

Laws condemned interracial sexual relations, but insisted that the "Eurafrican" children should be looked after. He believed that unless they were taken care of they would inherit *"the vices of both parents and the virtues of neither"*, and would become a *"serious menace to the welfare of the country"*. In a

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[127] Laws to H.E. the Governor of Nyasaland 27 February 1912. MNA 47/LIM/1/1/13, 845; Packard 1993.

[128] Laws to H.E. the Governor of Nyasaland 27 February 1912. MNA 47/LIM/1/1/13, 845. For sexual crime and violence in early twentieth-century Southern Africa, see McCulloch 2000; McCulloch 2004.

letter to the High Court Judge Beaufort in 1907, he stressed that the missionaries felt that it was their duty to help in the education of these children, but would not be able to take responsibility for them in the future.[129]

In his letter of 1912, Laws appealed to the Governor over the issue of "Eurafrican" children. He argued that European fathers should be bound by law to take full moral and economic responsibility for the welfare and education of their children, instead of providing only *"the merest pittance offered to the Missions as a means of silencing conscience"*. European sexual behaviour and the indifference of colonial law were "germs" that could result in loss of African sexual self-control, which could lead to interracial rape, if not checked by "even handed justice".[130] Emotions and passions were central to Laws' theory of sexuality, discipline and moral control. His analysis of the 1915 Chilembwe uprising again emphasised European responsibility and the dangers of uncontrolled "passions". In his view, the underlying cause of the uprising was the unjust treatment of Africans, which resulted in burgeoning resentment, building up of "passions" and, ultimately, in violence.[131]

Laws reiterated his views a year later in his response to an administration enquiry about whether there had been any correspondence between an African male and a "European school-girl resident in United Kingdom", which might lead to an "evil result". Laws assured the official that no such correspondence existed, and that he personally checked all incoming and outgoing letters sent between Institution pupils or teachers and Europeans. He stressed the value of Euro-African correspondence, and added that the respect shown to Europeans in the Protectorate depended largely upon European behaviour:

> With regard to "the severe legislation which has elsewhere become necessary to protect the women of the ruling race", my conviction is that if half this "severe legislation" had been applied to the European perpetrators of wrong on the women of the ruled race, we have thus been largely the teachers of the evil deplored, then the other half of "the severe legislation" would not have been called for. Any legislation dealing with matters involving the question of sex must have as its cardinal principle equal justice to all races and both sexes. Neglect of this principle has been the chief source of the failure of such legislation in the past, and will be so in the future.[132]

Following the outbreak of war in August 1914, Laws predicted dire moral and physical consequences, drawing from the experience of the "Arab war". His main concerns in this respect were intemperance and the transmission of venereal disease, and he requested that the authorities maintain the morality of the military. Furthermore, he printed leaflets advocating temperance to be distributed amongst the troops. The treatment of the wounded and convalescent brought British soldiers under Laws' care, and he hoped that their residence in Livingstonia brought them both physical and spiritual benefits.[133]

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129 Laws to Beaufort 9 December 1907. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1908, pp. 46-47.
130 Laws to H.E. the Governor of Nyasaland 27 February 1912. MNA 47/LIM/1/1/13, 845.
131 Livingstone 1921, p. 351.
132 Laws to Acting Chief Secretary 15 September 1913. MNA 47/LIM/1/1/14, 118.
133 Laws to Elmslie 12 April 1916. MNA 47/LIM/1/1/17, 230; Livingstone 1921, p. 351.

However, Laws' assessment of the moral (as well as physical) impact of the war was bleak. He held that it would take many years to restore the situation. He wrote to Wilson in April 1919, "*The missionaries of lust, falsehood & theft have had a fruitful innings to the advantage of the kingdom of Satan.*" He believed that the "frightful conditions" of the Arab war, when venereal disease had spread rapidly among the population, had been reproduced in Karonga and elsewhere.[134]

Health and politics in the Mombera Native Association

Laws' later analyses and the opinions he expressed as a doctor to the colonial authorities would provide ample material for those wishing to criticise colonial rule, and policies, as well as European conduct in the Protectorate, on medical as well as moral grounds. However, Laws and other Livingstonia missionaries remained publicly silent on many sensitive issues. The Livingstonia-educated elite who played a prominent role in the church and in local politics in Northern Malawi during the inter-war period utilised the missionary discourse and language about illness and health to their own ends, as the arguments of Mombera Native Association (MoNA) in the early 1920s demonstrate.

Public health issues had been prominent in discussions and debates in the Native Associations of Northern Malawi from their inception. In the North Nyasa Native Association (formed in Karonga in 1912) personal improvement, infant mortality and sanitation were all discussed together with village reconstruction and marriage payments. The local missionary attended the meetings and the government medical officer gave lectures on public health.[135] The war disrupted the association's activities, but from 1919 onwards, the new associations, in which Livingstonia graduates played a central role, emerged as important local forums of discussion. The founding members of the MoNA, which brought together the Christian elite and the ruling chiefs of the Jere clan in uNgoni, included Hezekia Tweya, Charles Chinula, Yesaya Chibambo and Mawelera Tembo. The ravages of war, the post-war economic slump and the influenza pandemic meant that issues of health and illness were particularly important within the region, but the Association was also concerned with the moral health of their society and with the behaviour of European colonialists.[136]

At the meeting of September 1921, members of the association observed that, "*European and Asiatic women are strictly preserved by law, while Native women*

134 Laws to Wilson 24 April 1919. MNA 47 LIM/1/1/18; Laws to Acting Chief Secretary 31 July 1919. MNA 47/LIM/1/1/19, 173.

135 Cook 1975, p. 101; McCracken 2000, p. 305.

136 Minutes of the MoNA 26-27 September 1921. MNA S1/210/20; McCracken 2000, pp. 316-317 and *passim*. Of the founding members of the Association, twenty-two were mission teachers (nine of whom became ordained ministers), eight were government clerks, two ordained ministers, two chiefs, one chief's councillor, one village headman and one cook. The ministers and the chiefs had all previously been mission teachers, as had all but one of the clerks. Many of the early members were elders in the church and the first President and the two secretaries had been representatives in the Presbytery for many years. Cook 1975, p. 103.

remain unprotected by the Govt. in the Protectorate." They argued that "Eurafrican" children were "*despised by both European and Native Communities"*, and requested that the Government provide legal *"protection of Native women in Nyasaland from this evil custom"*.[137] "Evil custom" was a term typical of missionary language that was used to condemn various African practices. In this critique of European sexual behaviour the association echoed the arguments that Laws had put to colonial authorities in the 1910s. In their appeal, they used missionary rhetoric to denounce European sexual indulgence and co-habitation with African women. At the same meeting, the Association defended the rights of African men to wear hats and other European clothing for reasons of health:

> ...some natives have been wearing these clothes for a long time, and are now accustomed to these things, and to ask them to put off these things, is just hurting their bodies...On the other hand, the members regret that many natives, through ignorance, put on clothes, which do not suit the climate. This, in return, brings damage to their bodies, and if this can be wisely and sympathetically pointed out to them by their European friends, as some Europeans do, they will understand it better, than doing it in a bitter way, and so causing dissatisfaction among Natives.[138]

Arguments based on the need to maintain the health and well-being of Africans were used to demand equal, respectable treatment from Europeans. Before the war European dress (particularly shoes and hats) had become symbols of equality and independence for the Protestant elite in Nyasaland. However, the Association was prepared to accept friendly, respectable European advice regarding the healthiness of African clothing. It was exactly this aspect of the discussion that the administration seized upon in its reply, claiming that the wearing of European clothes was primarily discouraged for health reasons. In this way the issue of disrespectful European behaviour was sidestepped altogether. A specific example of this type of behaviour could be seen in European responses to African wearing hats in their presence: in both Nyasaland and Rhodesia, those Africans who did not take their hats off when passing a European frequently had them knocked off.[139]

The administration placed all responsibility for cohabitation and sexual liaisons between European men and African women upon African society and upon women, in particular. The government claimed that *"the most effective remedy lies...*[with the African women] *who can avoid the evil consequences complained of by refusing unions not of their tribe or race."* The Association disagreed, and in a meeting in July 1922 argued that the responsibility lay with the colonial authorities, not with individual Africans or "foreigners". They claimed that the practice of cohabitation was brought to the district from elsewhere in the Protectorate by foreigners, who the local population imitated. They feared that *"venereal disease will spread into the District because of this*

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137 Minutes of the MoNA 26-27 September 1921. MNA S1/210/20.
138 Ibid.
139 Acting Chief Secretary to the Provincial Commissioner, Northern Province, 24 October 1921. MNA S1/210/20. Cook 1975, p. 113; Linden 1974, p. 80.

pernicious practice, and also that it will create disorder in the District".[140] For the sake of health and order, they appealed to the Governor to reconsider the issue. This meeting, presided over by chief Amon Jere, with Yesaya Chibambo as secretary, took place at the Loudon mission station. It is possible that the resident missionaries were indirectly involved in the appeal. In any case the appropriation of missionary language in the association's rhetoric is striking.

The colonial administration's response again emphasised sole African responsibility. It was argued that the Principal headmen and "native clergy" would be more efficient at preventing interracial unions than any possible legislation, *"even if such legislation could be made effective".* Parents simply should not let their daughters be with European men regardless of any monetary incentives. Furthermore, the local communities should regard a cohabiting woman *"as disgraced and no men of her own race should consent to marry her after she leaves the foreigner. In Europe such would be the case."*[141] The authorities claimed that shame and the social rejection of cohabiting women, comparable to lepers, would be the most effective means of preventing interracial sexual liaisons. Therefore, the stigmatisation of women, which was for the association a terrible result of cohabitation, was for the colonial authorities, a solution. The administration's emphasis upon women's responsibility and the duties of the "tribal" authorities and the church were in direct opposition to the social purist views of Laws, and the association's demands for effective legislation to ensure the protection of African women and society from concubinage, social disorder and venereal disease.

In respect of hygiene and sanitation in the villages, the association stated in 1922 that although the Resident had addressed the issue two or three times at the District Council,

> people do not pay any heed at all to what is said. All the members agreed that the laws of sanitation are quite necessary, and that they should always be setting a good example of this. Members...however feel that the greater bulk of the community do not realize any good benefit in this, and that a long time may pass before they come to know the good of it.[142]

They petitioned for the appointment of one or two "special capitaos" to help the Medical Officer in the promotion of hygiene regulation. In response, the administration stated that the legislation placed the responsibility for village sanitation on the village headmen and the principal headmen. The Principal Headmen should report all sanitary offences directly to the Resident, who could punish the offenders. No "special capitaos" were therefore required according to the Administration.[143]

The association was also concerned about spread of cattle diseases, tsetse fly, and sleeping sickness. They pointed out that there was already a sleeping

140 Minutes of the MoNA 26-27 September 1921. MNA S1/210/20; Minutes of the MoNA 28-31 July 1922. MNA S1/210/20.
141 Chief Secretary to Secretary, MoNA, 19 December 1922. MNA S1/210/20.
142 Minutes of the MoNA 28-31 July 1922. MNA S1/210/20.
143 Chief Secretary to Secretary, MoNA, 19 December 1922. MNA S1/210/20.

sickness case at the Mzimba hospital, and argued that the country was in serious danger. As a solution, they requested that, *"game and lions should be chased away."* Furthermore, the association was particularly concerned about lepers and leprosy. They argued that *"this disease is very hideous and contagious, and a great danger to the population"*. Thanking the government for the establishment of a Lunatic Asylum in Zomba, they hoped that the Governor would now consider the question of lepers in a similar fashion, and devise measures of *"how it can be lessened or even terminated"*.[144]

The government replied that unfortunately there was no money available to fund leper asylums. Instead, it was suggested that village headmen should build remote huts for lepers and that lepers should not be in close contact, and in particular were not to eat or drink, with others.[145] The association's requests for anti-tsetse fly measures, including the right of Africans to chase away game and lions, were ignored. The patronising responses of the authorities on issues of health, which stressed African moral, legal and economic responsibilities, through the framework of indirect rule, while refusing to provide them with any real authority, legal or economic support, bring into sharp relief the colonial mentality and the political and socio-economic realities of Nyasaland Protectorate in the 1920s.

In 1926, the association discussed the causes of deaths within uNgoni and possible methods to lessen mortality within the region. The first cause discussed was "bad medicine", which was used especially by women married against their will who added the medicine to their husband's food, as well as by men who put medicine into their enemies' beer. Women were also blamed for "women's diseases" i.e. those diseases spread through "adultery and fornication" and, in this case, the association's attitudes were notably patriarchal. Generally, it was observed that some diseases were the result of *"Disobedience to the law of Sanitation"*. The association agreed that:

> Those who travel in different countries, come back with different diseases for which no medicine can be found in the country, and so those who are caught with such diseases, fail to be healed, and so die.

Furthermore, it was agreed that:

> Civilization, which is quite a new thing in the country, has brought both good and bad things, among which, are diseases which cannot be treated effectively by native doctors, e.g. Consumption and Influenza.

"Superstition" was singled out as contributing factor, as it, *"instead of protecting, creates fear which puts out faith in a sick man who dies for want of faith."* Finally, the association condemned early marriages, which were seen as the result of a relaxation of the old Ngoni marriage code.

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144 Minutes of the MoNA 28-31 July 1922. MNA S1/210/20.
145 Chief Secretary to Secretary, MoNA, 19 December 1922. MNA S1/210/20.

The association suggested a number of methods to combat these dangers to health. People with a "foreign disease" were advised to visit the government medical officer at Mzimba. Early marriages were discouraged, and it was advised that no one should be married against their will. Gradual education was required to teach the importance of sanitation. The belief in unspecified "superstition" was to be broken and beer should be drunk with care, a compromise between total abstainers and more liberal members of the Association. Finally, those who were heard to publicly threaten "mischief" were to be sent by the chiefs to the colonial authorities at Mzimba, where they would be *"tried according to the law of threatening & attempting to murder."*[146]

The association shared a number of missionary concerns and used similar language to point out the hazards of "disobedience to the law of Sanitation", "superstition", beer-drinking and early marriages. However, they also emphasised that the "foreign diseases", notably consumption and influenza, were brought by "civilization" and that they were beyond the skill of local healers in part because they originated in "foreign lands". Furthermore, in their concerns about "bad medicine" and the need for menacing individuals to be tried according to the law, they reflected a central concern of Ngoni society, namely those illnesses and deaths caused by individuals, which would previously have been referred to explicitly as witchcraft or sorcery. It is significant that the psychological explanation of the deadliness of "superstitious beliefs" (which was shared by many missionary doctors) formed part of the argument presented to the colonial authorities. The association, which consisted of senior men only, clearly blamed women for many illnesses and seemed to want a return to the old codes of marriage and morality in society. Here the contrast to Laws' views on social purity and the responsibility of men are striking, although Laws also admired "old Ngoni morality".

It is also important that while those with "foreign diseases" were advised to go to Mzimba for treatment, missionary medicine or hospitals are not mentioned at all. The 1926 association minutes are evidence that the chiefs and Christian elite were beginning to categorise "foreign" diseases as a new type of disorder caused by colonial rule and "civilization". These "foreign diseases" were beyond the skill and medicines of the healers of the land, and required treatment by Europeans, representatives of the "civilization" which had brought these illnesses to the region in the first place. Whether missionary medicine was seen by the association as being in any way distinct from secular colonial medicine cannot be discerned, but clearly in 1926 the Ngoni leaders were not looking to Livingstonia and its remote central hospital as a solution to illness and death in their society.

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[146] Minutes of the MoNA 26-27 May 1926. MNA S1/1365/24. Arguably, the importance accorded to the role of "faith" in healing may have contributed to the acceptance of faith healing in society, but this complex question is beyond the scope of this enquiry.

11 QUESTS FOR HEALTH IN AN AFRICAN CHURCH, 1900-1930

11.1 Prayer, healing and the first-generation Christians

While Laws' theory allowed that God's spirit could heal physical illness and restore health through energy, a principle that in theory legitimised faith healing through prayer, he was careful never to undermine the authority of scientific medicine. W.P. Livingstone believed that Laws had "strange force in prayer, but of that one cannot write". Although Laws always operated with a prayer, and believed it was "the irresistible molecular force of Christianity",[1] it is unclear how common this practice was among the African Christians. Apart from the case of Prentice treating Murray (discussed above) there is no evidence that younger missionary doctors combined prayer and medicine in their practice. However, Laws frequently mentioned in his letters to evangelists, teachers, and former Livingstonia pupils that he and Mrs Laws prayed for them, often in times of illness or bereavement. Laws also sent medicines to them by post, and it is plausible that on occasion his prayers were believed to have some healing power. The younger non-medical missionaries also prayed for health; for example, in 1923, the Martins were asked for medical help by Cheruvya, the headman of Luluzi, for his wife. They wrote to him that they could not help her medically, but would pray for her, and later received a "large thank offering of fresh fish" with a note stating that the headman's wife was better.[2]

Prayer was one feature of Christian religious practice which was likely to be understood by many Africans literally for the purposes of health, wealth and increase. At the outbreak of the rainy season in 1886, a year after the drought and the "Rain Question" in uNgoni, Elmslie believed that the Ngoni belief in

1 Laws, quoted in Livingstone 1921, p. 362.
2 Martin 14 April 1923. Sinclair 2002, p. 133.

spirits capable of withholding rain proved the existence of indigenous consciousness of sin, and believed that this could be used in conversion:

> We have but to read the preludes to the judgements of God on Israel to show them that if God denies there must be some reason to be found in our conduct towards Him, & so we fall back on the Decalogue and measure our conduct by it. They can appreciate this version of the case...[3]

The stern Old Testament God punished according to natural laws, and repentance would result in forgiveness and the return of God's gifts. In a society threatened by droughts and famine, and in a culture where rain cults performed a crucial public health function, Elmslie's preaching was interpreted literally. Whilst waiting for the rains in late 1886, Elmslie had put the half-dozen mission "boys" (including the Tembo brothers) to *"in turn engage in prayer or repeat the ten commandments every Sunday in the Church meeting."*[4]

Faith healing was undoubtedly practised to some extent by the early African evangelists and teachers. For instance, Christian teachers from Bandawe congregation who had been working in the mission field of Marambo reported to MacAlpine in 1907, after their first five months of work, that their prayers had been answered. Rain had fallen ending the drought, the wind had blown away the locusts threatening the crops, and in one case prayer had healed the child of a woman who had attended the mission school and repeatedly prayed in church, instead of consulting the diviners.[5]

Some of the European missionaries also believed in the mystical healing power of prayer. While Alexander Caseby was suffering from a severe malaria attack in the countryside, he woke up at night and heard his students praying for his recovery. Caseby experienced this as a revelation of his students' loyalty, and as he listened to the prayer his pain seemed to disappear for an instant, but he felt that his own faith was weak.[6] In 1929, while Caseby was on a motorcycle-trip to Loudon, he met an African woman with a sick child en route. The woman asked Caseby to bless the child in prayer and with his hand. Caseby recalled, *"Here was a challenge to my belief...I laid my hands on the child, prayed, offered some words of comfort, and as I had no medicine wrote a note to the Mission Doctor."* He asked the mother to take the child to the doctor, and gave her some money. Between Ekwendeni and Loudon, Caseby had an attack of fever and crashed his motorcycle, finding himself in the bush away from the road and with no memory of the previous twelve hours. He survived and was treated by an Indian doctor at the Residency. On his way back, Caseby saw the woman and her child, who was now fully recovered, as they were returning home from the hospital and he believed that their prayers and blessings had, in turn, saved him.[7]

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3 Elmslie to Laws 22 November 1886. NLS, Acc. 9220 (1) (iv).
4 Ibid.
5 MacAlpine 29 November 1907. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1908, pp. 32-33.
6 AUL, MS 3289, Caseby Papers, No. 9.
7 Ibid., Nos. 29-30.

However, the Christian combination of prayer and individual healing was not universal. On the Khondowe plateau, the Phoka had "traditional prayers" in cult rituals for communal health. According to one interviewee, *"After the introduction of Christianity, there was nothing like praying for the sick because they* [the people] *then realised that the real healers were God and the hospital."*[8] However, he also recalled hearing that Laws used to pray with and for the sick. Another informant recalled that early reverends such as Andrew Mkochi and Charles Chinula did not combine prayer with medicines, unlike the *vimbuza* healing specialists who adopted prayer as part of their practice.[9]

11.2 Medicine, morality and the Presbytery

The Livingstonia Presbytery met for the first time in November 1899. At first dominated by missionaries, by the 1910s, the majority of members of the Presbytery were Africans. Initially there was only one African elder from each major congregation, but from 1907 the congregations were entitled to send one elder for every three hundred members in full communion. Although the missionaries continued to wield considerable influence within the Presbytery, and the missionaries' exclusive Mission Council remained the main decision-making body of the mission, the Presbytery and Kirk sessions were not merely "rubber stamping organisations" as Thompson has pointed out. It is noteworthy that in the early 1900s neither the missionaries nor the African Christian elite were cohesive groups in the Presbytery, but formed fluctuating alliances and smaller sub-groups. The Kirk Sessions provided a forum for important discussions at a local level, although their power was severely checked by the Presbytery and the Mission Council. However, from 1913 onwards all major legislation in the church had to be discussed and approved in the Kirk Sessions before it could become effective.[10]

In the Catechumen's Vows as approved by the Livingstonia Presbytery in 1900, the catechumens committed themselves to learn about and serve Christ, to engage in regular private and public worship, to marry monogamously, to support the church and to educate themselves and their children about the

[8] Oral testimony, S.M. (b.1932), 8 July 2004.

[9] Oral testimony, S.M. (b.1907), 12 July 2004.

[10] The conservative missionary block of Laws, Elmslie, MacAlpine and McMinn was often opposed by the more theologically liberal group of Fraser, Mackenzie, Prentice, Chisholm and Cullen Young, although these groupings were not static. Likewise, on the African side, E.B. Manda, Y.Z. Mwasi and Yesaya Chibambo were more "radical", challenging the missionaries more often, while Yuriah Chirwa and Peter Thole, for example, were more likely to follow the missionaries and Laws in particular. Thompson 1995, pp. 153-161. Thompson has argued that in fact, the barrier act of 1913 did not substantially alter the balance of power between local church and the missionaries. Until 1914, when the first African ministers were ordained, all Kirk sessions were chaired by European ordained missionaries as moderators. This gave individual missionaries with authority, such as Laws and Elmslie, considerable control over the local congregations.

Word of God. Furthermore, they also vowed *"to abstain from all things contrary to the Word of God."*[11] This commitment and the definition of its meaning formed the basis of the ideas, policies, discussions and controversies about the relationship between Christianity and African customs and practices. Who defines what exactly is contrary to the Word of God is fundamentally a question about authority, power and hegemony in the church and congregation. Formal decision-making was the preserve of the missionaries during the early years of the Presbytery. However, there was some room for debate and controversy stemming from the vague definition of exactly which practices were un-Christian. It was the role of the Presbytery and the congregations, under missionary supervision and guidance, to deal with questions and problems as they arose.

> Christians should not taste, speak, do not have any connection with heathen evil customs which are contrary to the Progress of Christianity. They should be resolute and not to yield to any evil thing and win men thereby – such as beer-drinking, polygamy, uncleanness, &c. In order to overcome these Christians should live a holy life, and preach constantly against them…[12]

In January 1908, these excerpts from the recommendations of the Native Christian Conference in Livingstonia were read and adopted by the Presbytery, who ordered that they should be circulated among the Congregations. They echoed the missionary concern with beer-drinking, polygamy and "uncleanness"; the latter term having strong moral, physical and sexual overtones in Victorian and Edwardian usage. However, with regard to African healing practices, the policy was unclear. If these customs belonged to "heathen evil customs contrary to the Progress of Christianity", they obviously were not to be tolerated. Christians were expected to preach against such customs at every opportunity. It is significant that the conference prohibited Christians from speaking about or tasting evil customs, with the possible interpretation that "evil and heathen" medicines should not be ingested and that verbal magic should not be practised. However, there was no clear overall policy on African healing and medicines.

The African church leaders also felt that the issue needed clarification, and it seems that the use of what Europeans called "charms" was a particularly problematic question. In 1912, Edward Boti Manda, a leading Institution teacher proposed that "*the question of the use & practice of charms, superstitions and such like of Christians, be referred to Kirk sessions for full consideration and report to next meeting of Presbytery*". His motion was seconded by Yuriah Chirwa, Laws' right-hand man, and the resolution was carried.[13] A day later in the Mission Council a similar suggestion was raised. Missionaries from each district were to report on the local "heathen practices", on the grounds that many such practices and superstitions were still exerting a "detrimental influence" in the Christian community. The following year, missionaries duly handed in reports on the

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11 Livingstonia Presbytery Minutes, 2 November 1900. MNA 47/LIM/3/21.
12 Livingstonia Presbytery Minutes, 30 January 1908. MNA 47/LIM/3/21.
13 Livingstonia Presbytery Minutes, 16 October 1912. MNA 47/LIM/3/21.

issue.[14] However, it was not until 1914 that the issue was formally discussed again in the Presbytery.

In May 1914, the Presbytery approved the proposal of its Moderator, Innes, that a committee should be formed to discuss the *"use and practice of charms and superstitions by Christians"*, and to *"consider terms, and define the meanings of words used in this connexion"*. The Committee was composed of seven African elders (Filemon Chirwa, James Nyirenda, Jonathan Chirwa, Mark Mwakawanga, Edward Boti Manda, I. Stima and Jonathan Simfukwe) and three Europeans held to be familiar with the subject (Elmslie, Chisholm and Innes – all missionary doctors).[15]

Silas Ncozana has argued that the committee represented a "purely medical" missionary attitude to phenomena such as spirit possession, that it produced its report "on the spot" in 1915 and that its conclusions were "formed from existing opinions without fresh and thorough study of the subject". Ncozana suspects that the committee only met once.[16] However, it can be argued that the roots of the Charms and Superstitions Committee (hereafter the CSC) went back at least to 1912, when Manda and Yuriah Chirwa proposed that the Kirk Sessions should discuss "charms and superstitions" and subsequently present a report to the Presbytery.[17] It should be remembered that 1912 was the year that the first Native Association was founded in Karonga, and that the debates about African beliefs and practices took place in the context of the increasing organisation of the Christian elite – churchmen as well as educated graduates and pupils of Livingstonia. Furthermore, in 1911, colonial authorities in the Nyasaland Protectorate had passed the first Witchcraft Ordinance, which effectively criminalised those making witchcraft accusations. This decree was a considerable challenge to prevailing African theories of illness and health, and medical as well as judicial practice.

In Livingstonia, by 1912 both African elders and missionaries were concerned about African practices in the Christian community – , referred to as "charms and superstitions" in missionary language. The definition of "charm" itself was not necessarily clear. For instance, in Laws' English–Nyanja dictionary published in 1894, the verb "to charm", *ku tsirika,* was explained as *"to fortify with charms against evil; e.g. to vaccinate, or to put up a lightning conductor"*.[18] This indicates something of the complex ongoing processes of translation and definition between missionaries and Africans, for the same term could refer here to magical charms or to vaccination or protection against lightning, both of which were perfectly rational actions for Europeans. The issue of indigenous medical practices, which was first raised by the elders, was crucial in this debate. However, the missionaries' views were more prominent

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14 Minutes of the Mission Council, 17 October 1912 and 14 October 1913. MNA 47/LIM/3/17.

15 Livingstonia Presbytery Minutes, 19 May 1914. MNA 47/LIM/3/21.

16 Ncozana 2002, pp. 152-153.

17 Ibid. Ncozana seems to suggest that if the CSC had included ordained non-medical ministers, its approach to spirit possession might have been different. However, it should be noted that all the doctors involved were also ordained ministers.

18 Laws 1894.

in the later written record. Manda and Chirwa's plan had been to discuss the issue in individual congregations where the African elders would have had more influence, while the missionaries considered the matter in the exclusive missionary council and established a central committee run by missionary doctors. Missionary dominance at an organisational level seems clear. However, the precise definitions of words and concepts were crucial in determining which practices were to be condemned and which could be tolerated. Such work could not be achieved without the co-operation of local Christians across the large Livingstonia sphere, where a number of vernacular languages (Tumbuka, chiTonga, chiNgoni, chiChewa, chiNgonde and Inamwanga, at Mwenzo, among others) were spoken. At best, the missionaries would have had only partial knowledge of these languages and the specific terminology of illness, health and medicine, thus limiting their rhetorical power and their hegemonic aspirations over the African congregations.

According to the Presbytery minutes, the Charms and Superstitions Committee was formed in 1914, and at the meeting of August 1915 Dr Innes, the Committee's Convener presented the report. This report was then distributed among the members of another committee, consisting of all the African members of the Presbytery (chaired by Jonathan Chirwa) for "careful consideration and report". Finally, Innes read the report of the CSC along with the commendations of the second, temporary, committee. The CSC was thanked and asked to continue its work.[19] In the Presbytery of October 1916, George Nyasulu, Y. Banda and Adamson Simwana joined the committee. Three days later, the Committee presented the second part of its report, and was thanked and dismissed.[20] This shows that the CSC met more than once. Although its conclusions may well have been formed from existing opinions without further study (due to the war) and the fact that the missionary doctors undoubtedly made crucial decisions about the form and content of the document, Africans made a notable contribution to the preparation of the report, which was written in both English and Tumbuka.[21]

The CSC report and the Presbytery resolutions

As Ncozana notes, "*Virombo*" spirit possession was classified not as a single disease in the report. The term was used, according to missionary doctors, "whenever a disease is chronic and intractable". The report stressed that dancing and drumming could not cure such diseases, but would *"only deceive people and strengthen their faith in idle things"*,[22] and that, therefore, dancing and

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19 Livingstonia Presbytery Minutes, 26-28 August 1915. MNA 47/LIM/3/21.
20 Livingstonia Presbytery Minutes, 18-21 October 1916. MNA 47/LIM/3/21.
21 The second part of the Report was written only in Tumbuka and was included as an appendix to the Presbytery minutes.
22 "Charms and Superstitions Committee Report", Livingstonia Presbytery Minutes, 26–28 August 1915. MNA 47/LIM/3/21. The Tumbuka text was translated by Gift W. Kayira.

drumming should be condemned. Significantly, the CSC did not make their case against dancing and drumming on the basis of any psychological or "neurotic" influences or on medical grounds – as was the case in some missionary condemnations of possession. Dancing and drumming, according to the CSC, could encourage deception and idleness, classic objects of derision for Scottish as well as African Presbyterians. The committee, and the Presbytery, resolved to warn Christians against dancing and drumming, but importantly *"not against the mere drinking of medicine."* Furthermore, in a later section, it was ruled that,

> "Mfizi" amulets, philtres &c. as for example against snakes, and other medicines which people consider potent against disease, when they use them by swallowing, or inunction, or wearing the Church does not desire to condemn, because perhaps some of them are of real help to people; though others are useless and without slightest healing power, their use is, we think, a matter of ignorance only.[23]

This was the final verdict of the Presbytery. It seems that this was not merely the hegemonic view of the missionary doctors, but rather a statement of consensus and compromise. The fact that certain types of "amulets, philtres &c." were to be tolerated, regardless of whether they were swallowed or worn, was significant in principle. Many missionaries privately thought that certain African remedies could have some real value. Western doctors could understand that some ingested or inhaled herbal medicines, particularly those used to treat snakebites, could have some therapeutic properties.[24] However, the acceptance of something worn for protection, such as amulet, was distinctly more liberal. The CSC acknowledged that some of these practices were "useless and without the slightest healing power", but the decision itself allowed some tolerance and flexibility, at least in theory, to congregations, ministers and individual Christians.

This tolerant attitude towards *"Mfizi"* is in stark contrast to other sections of the CSC Report. "*Misinkho*" (translated as "*charms*") were declared to be "useless and powerless" and people were warned against them. Section III condemned *"Wurumba" ("for rubbing into cuts &c.")* and "*Mpozwa" ("for weaving into fishing nets &c.")*. These practices seem varied, involving people as well as objects, and were generally condemned as mischievous or ludicrous, or as having *"a real hindering or dwarfing effect on the faith of Christians. Some…of them are interwoven with filthy or shameful customs and lead to real evil…"*[25] Here the condemnation was based on spiritual, sanitary and moral grounds rather than on medico-scientific arguments.

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23 Ibid. In the Tumbuka text, a reference is made to *medicine which heal peoples diseases when they drink, or lotion their bodies* – but does not mention wearing of amulets. It is noteworthy that snakes are specifically mentioned in the English text. Antidotes to snakebites were among the most appreciated indigenous therapies among white doctors in South Africa. Lalu 1998.

24 Hokkanen 2004; Lalu 1998.

25 "Charms and Superstitions Committee Report", Livingstonia Presbytery Minutes, 26-28 August 1915. MNA 47/LIM/3/21.

The Livingstonia missionaries' condemnation of "charms" extended beyond the "heathen" population. Many Catholic and Islamic objects and practices were scornfully regarded as superstitious charms by Protestants. In 1905, following the arrival of the White Fathers in the Mwenzo area, Chisholm wrote:

> The long robes, the wearing of rosaries, the Latin repetitions, the bowing to the cross and images, the kissing of the Bishop's ring, and the celibacy of the missionaries, all combine to nurture the superstitious element in the native.[26]

For Chisholm, Catholic rituals strengthened the "native superstitions" that the Protestant doctor was fighting against with his rational agenda of science and true religion. It is noteworthy that Chisholm refers to the celibacy of Catholic missionaries, suggesting that, in common with many Protestants, he regarded celibacy to be a mystifying, irrational and even unnatural attitude towards sexuality. However, within the local context the Protestants' Bibles, medicine-bottles, and fly-switches could also be understood as "charms" or "medicines" imbued with special powers, as T.C. Young observed.[27]

The report condemned "Miraza" (Ngoni widows' mourning caps etc.) as being filthy and hazardous to health, and, in a curious Bible quotation, reminded church members of I Cor VI: 19.[28] This passage, usually used in the West to condemn sexual immorality and masturbation, was used here in the context of burial and mourning customs, as a general condemnation of "uncleanness". Biblical authority reinforced sanitary arguments for the prohibition of these items and practices. More constructive was the criticism and condemnation of "Mboto" and "mibimira" practices used to increase crops and property. The CSC report suggested that, instead of using these practices, Christians should hold special prayer gatherings at "seedtime" and harvest, where they could acknowledge God as "the Increaser as well as Giver of wealth and food."[29]

The metamorphosis of men into animals was dismissed as being "mere tale" in the report while "omens" (*Miziku, mintondwe*) were referred to as "ignorance" that would die out by itself. In contrast, the committee strongly condemned *"all customs that prescribe certain abstinences on account of mode of birth"*, as well as the general *"abstinence to avoid defilement from women"*. "Defilement" here refers to eating food cooked by a sick woman or touching her mat or clothes. Echoing the medical missionary view, the report stressed that people should rid themselves of notions that such defilement could cause diseases such as leprosy.[30] Here the medically-informed Presbytery was

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26 Chisholm 3 January 1905. NLS, Acc. 7548 D 71.

27 Young 1931, pp. 119-120.

28 "Charms and Superstitions Committee Report", Livingstonia Presbytery Minutes, 26–28 August 1915. MNA 47/LIM/3/21.; This passage reads in a modern translation, *"Or do you not know that your body is the temple of the Holy Spirit who is in you, whom you have from God, and you are not your own?"* and, significantly, is preceded by a warning against sexual immorality which is a sin against one's own body.

29 Ibid.

30 Ibid.

completely and unequivocally opposed to local and regional theories of disease causation including the *tsempho/mdulo* concept and the generic idea that menstruating women were "hot". Menstruating women were believed to have the potential to cause illness in others either directly or through the medium of salt, food or clothes. It is noteworthy that here "leprosy" is singled out as a disease resulting from "defilement" by contact with "hot" people. As Lwanda has noted, the skin manifestations of leprosy were commonly regarded to be "hot".[31]

Western doctors could diagnose those who had "hot" symptoms, including ulcers and swollen tissues, as suffering from leprosy, or yaws, syphilis or other diseases. Morris has stressed that the Chewa disease categories are "largely based on the 'symptoms' of disease".[32] A missionary doctor could diagnose a patient with "hot" symptoms to be suffering from syphilis, while an African practitioner might diagnose his illness as being the result of an illicit sexual relationship. Both practitioners would view the patients' illness to be the result of moral transgression and sexual intercourse albeit in different ways. In theory, therefore, not only differences but also common aetiological ground could be found between African and Western disease conceptions of ailments with symptoms of swelling and ulcers. The definition of illness and its social framework are crucial issues of negotiation and contestation and, as noted below, leprosy attained a specific significance for African Christians in Livingstonia. Finally, the CSC Report unambiguously condemned "*Bad Medicines. Such "medicines" as injure people or cause sickness or death*" as "*altogether evil*". Those medicines used to manipulate the course of justice or conceal adultery were also deemed to be "quite unworthy of Christians".[33]

During the Presbytery meeting of October 1916, the committee completed its report. *Wazambi* (midwives or "counsellors"), witchcraft and certain family taboos and precautions were discussed. The examination of girls before marriage or in cases of suspected sexual immorality by local midwives was generally condemned due to the perceived corruption and untrustworthiness of the midwives. However, the Presbytery ruled that Christian parents were allowed to have their daughters examined, but that they should select only trustworthy and committed midwives.[34]

On the subject of witchcraft, the committee unequivocally asserted that no cannibalistic, shape-changing people actually existed. Furthermore, they dismissed *seketera* (the art of driving witchcraft out of an alleged witch), *chirondora* (the art of destroying the witches' "charms" or harmful medicines) and "even" *kuwukwa* (the art of witch-finding) as lies.[35] The condemnation seems clear enough. However, it is important to note that while the report

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31 Morris 1985; Lwanda 2002.

32 Morris 1985, pp. 19-20.

33 "Charms and Superstitions Committee Report", Livingstonia Presbytery Minutes, 26-28 August 1915. MNA 47/LIM/3/21.

34 "Completion of report of committee on Charms and Superstitions", an appendix in Tumbuka in Livingstonia Presbytery Minutes, 21 October 1916. MNA 47/LIM/3/2. Translated by Gift W. Kayira.

35 Ibid.

categorically denied the existence of cannibalistic witches, and declared certain methods of witch-finding and witch-cleansing to be lies, it remained silent on other matters. Anthropologists have argued that in the Malawi and Zambia region, a distinction should be made between the cannibalistic "true witch" and the "killer-for-malice" who both use "bad medicines". The latter refers to cases where deadly medicines, *mankhwala,* are used maliciously, by an ordinary, non-cannibalistic member of a society. Wendroff has argued that in Northern Malawi all mystical/magical attempts to injure someone require the help of "bad medicines".[36] According to Marwick's study of the Chewa (in what is now north-eastern Zambia) all "mystical evil doers" (and poisoners) are referred to as *nfiti/mfiti*. However, in terms of motivation, there is a clear distinction between the "true witch" and the "killer-for malice": the first is cannibalistic and the second, an untrained evil-doer who kills or injures for malice (rather than for human flesh) and who has obtained destructive medicines from someone else.[37] With such a distinction in mind, it is significant that the committee never denied the existence of the "killer-for-malice", and that it merely outlawed and refuted the methods used to detect such a killer. Furthermore, the report clearly condemned all kinds of "bad medicines": the CSC indirectly recognised at least some of the material elements of witchcraft.

As Ncozana has pointed out, in the early nineteenth century the Livingstonia missionaries usually resolved Presbytery matters in their exclusive Mission Council.[38] However, it is argued here that the recommendations of the CSC, as approved by the Presbytery, were the result of continuing conversation and dialogue between missionaries, and influential African church leaders (including Edward Boti Manda, Y.Z. Mwasi, Yuriah Chirwa and Jonathan Chirwa). It seems that, although the CSC report reflected missionary doctors' condemnatory and derisory attitudes to many local theories and practices, the result in fact was a compromise that allowed African churchmen to tolerate or accept certain practices – notably the use of medicines that were ingested, put into cuts or used as lotions. "Charms" (*misinkho)* were condemned while *mfizi* amulets, philtres and "other medicines" could be tolerated. This ruling gave a degree of flexibility to individual congregations and church leaders who had to make immediate practical decisions on these complicated issues, usually beyond the reach of any missionary supervision. Arguably, this may have been the very objective that Manda and others had in mind when they initially proposed the discussion of this issue in the Kirk Sessions. Furthermore, the fact that the report did not rule out the existence of "killers-for-malice" who used "bad medicines", and the CSC's condemnation of "bad medicines" meant that they in fact existed for church authorities and the law, and could be discussed when classified as "poisoning".

At the time that the Committee concluded its report, African converts were taking on increasing responsibilities in the expanding church and the role

36 Wendroff 1985, pp. 21-24.
37 van Breugel 2001, pp. 213-216; Marwick 1970, pp. 78-79; Wendroff 1985, p. 23.
38 Ncozana 2002, p. 154.

of the missionaries was diminishing throughout the Livingstonia Mission. Even if the missionary doctors had wanted to propose an outright condemnation of all African medical practices (which is doubtful), they would not have had the means to enforce such a policy: the war was seriously disrupting all aspects of missionary work across the Northern Malawi region.[39] In January 1917, in the absence of any available European missionaries, the Presbytery sent Rev. Jonathan Chirwa and the licentiate preacher Andrew Mkochi to supervise Christian communities in the large Mwenzo and Chinsali districts.[40] In these circumstances, many African church leaders who were working some distance away from the hospitals and dispensaries would have to encourage, or at least tolerate, medical pluralism in their congregation's responses to illness and disease, and the Presbytery policies formulated during the period 1912–1916 allowed them to do so. It could be argued that the CSC report and the Presbytery rulings did not so much create, as confirm and consolidate a pre-existing pattern of medical pluralism among the Presbyterians of Northern Malawi that was largely invisible in the missionary sources. However, this hypothesis would need to be developed through a more detailed study of discussions relating to health in the Presbytery and the Kirk Sessions.

Divorce and disease

The Livingstonia Presbytery frequently dealt with cases and enquiries involving church members and issues of health and illness, particularly questions of marriage and divorce. The examination of some of these cases in detail can chart the use of medical/health arguments and rhetoric in debates and decision-making within the church. Granting divorces to a church member was one of the main duties of the Presbytery and the Kirk Sessions. Most cases dealt with in the early 1900s were clear-cut: polygamy and adultery were legitimate grounds for divorce. However, the Presbytery had to deal with a number of debatable cases.

In 1904, the Njuyu Kirk Session asked the Presbytery whether a woman could be granted a divorce on the grounds that her husband was a leper: the divorce was refused. Spousal "insanity" was also ruled out, in 1914, as legitimate grounds for divorce.[41] In 1905 and 1911, the Loudon Session presented two cases in which a divorce was requested on the grounds of "alleged attempted poisoning". In both cases, the issue was returned to the Kirk Session for further investigation. Remarkably, the Presbytery ruled, in 1913, that "Syphilitic Infection" was, in principle, sufficient grounds for divorce. The case brought before the meeting was from Karonga, where the husband of a church member, had committed adultery with a woman infected with syphilis.

39 Thompson 1995, pp. 175-176.
40 *The Livingstonia News,* June-December 1917, pp. 28-30.
41 Livingstonia Presbytery Minutes 6 October 1904, 15 May 1914. MNA 47/LIM/3/21.

The husband had been suspended from the church, and his wife was granted a divorce.[42]

In the early 1900s, then, leprosy and madness were not accepted as grounds for divorce, the attitude towards attempted poisoning was unclear, while "syphilitic infection" was deemed a legitimate complaint. Naturally, syphilitic infection during marriage was evidence that adultery had taken place, but it is significant that the medical aspect was so clearly emphasised in the Presbytery minutes. Medical authority reinforced the religious ruling and moral judgement. It should be remembered that in the early 1900s the symptoms of leprosy, syphilis and yaws often appeared to be very similar. As noted above, the skin manifestations typical of all these diseases – neuropathic ulcers and swollen tissues– were frequently classified as "hot" and potentially contagious in Central African theories of disease..[43]

During the 1920s, the issue of leprosy and marriage was frequently raised. In Karonga, a Christian man was disciplined in 1923 after marrying, "in a heathen fashion", a woman who had previously divorced a leper. By this time, leprosy was recognised by both local and colonial law as legitimate grounds for divorce, and the Presbytery had to recognise the authority of the Boma (which had sanctioned the divorce).[44] To avoid such situations, the Kirk Session at Livingstonia suggested that the church ought not to marry lepers, and a lengthy discussion in the Presbytery and the sessions ensued. In 1925, Livingstonia Kirk Session ruled that ministers were free to refuse to perform such marriages. Eventually, in 1927, the marriage of lepers was made illegal throughout the Presbytery.[45] This could be seen to conform to the pre-colonial public health principle of isolating the contagious "hot" people, who were now called "lepers" in English. While the church moved towards the isolation of lepers from the community, the colonial authorities were beginning to discourage compulsory segregation.[46]

In the case of insanity and divorce, the Presbytery was in opposition to the colonial administration. In 1918, the Kasungu session reported a case in which a church member's wife appeared to be "hopelessly insane". The husband did not request a divorce from the church, but the wife's parents took the case to Boma, and obtained a divorce from the magistrate. With some alarm, the Presbytery noted that according to the ruling of the Boma the husband could not remarry his wife even if she recovered. It was decided that although "*the highest Christian ideal for* [the husband] *is that he should remain single during the life of this woman*", if he could not "remain continent" then he should be allowed to remarry. However, it was clearly stated that in no way should this be

42 Livingstonia Presbytery Minutes 17 October 1905; 20 October 1911; 21 October 1913. MNA 47/LIM/3/21.

43 Lwanda 2002, pp. 65-67; Laws to Superintendent of Census 31 December 1925. MNA 47/LIM/1/1/25 (a), 318.

44 Livingstonia Presbytery Minutes, 14 August 1923. MNA 47/LIM/3/24.

45 Livingstonia Presbytery Minutes, 22 September 1924; 8 October 1925; 15 July 1926; 11 July 1927. MNA 47/LIM/3/24.

46 Good 2004, p. 341.

considered as a precedent to allow divorce on grounds of insanity.[47] *Vimbuza* spirit possession was insufficient grounds for divorce. In 1929, a member of Henga Kirk Session requested advice after his possessed wife could no longer live with him. Patience and "proper medical treatment" were advocated.[48]

The issue of poisoning deserves particular attention. According to Donald Fraser, in the 1910s and 1920s some of the cases of witchcraft accusations that concerned the mission and the colonial authorities were in fact cases of poisoning. Fraser argued that these cases should be dealt with as crimes instead of prosecuting the accusers on the basis of Witchcraft Ordinances. Considering the missionaries' condemnatory attitude towards anything connected to "witchcraft", it is not surprising that the Presbytery did not deal with accusations using such terms. While "witchcraft" accusations had been outlawed, it was acceptable to accuse someone of "poisoning". Fraser tried to solve this problem by separating "actual" cases of poisoning from the mass of *ufwiti* accusations, while also noting that in African culture there was no distinction made between deaths caused by magic or poison – both were the result of harmful "medicines".[49]

Fraser was Moderator of the Loudon Kirk Sessions during the early 1900s and his position undoubtedly influenced his thinking. Loudon sent both of the troublesome poisoning cases discussed above to the Presbytery. The minutes reveal that no clear ruling or policy was taken on the issue. The early converts could use poison accusations to bring cases to the attention of church authorities that would have been referred to as *ufwiti* locally. As "witchcraft" these cases would have been an issue that the missionary-chaired church meetings would have been unable to discuss and that would only have led to the accuser being disciplined rather than the accused. Marwick, in his study of the Chewa of North-eastern Zambia, doubted that the Chewa originally distinguished between sorcery and poison. He argued that, under colonial rule, the Chewa had "come to recognize that the Administration believes in one type of sorcery, viz. poisoning" and referred to this when they took *de facto ufwiti* cases to colonial court.[50] In Northern Malawi it seems that such reformulations of concepts and terminology began in early church meetings, legal cases, discussions and dialogues between the missionaries and the African converts. This was not merely a case of uncontested missionary hegemony.

Spirit possession

The CSC unambiguously agreed that *Virombo* spirit possession was not a valid disease category, and was strongly opposed to the drumming and dancing which were the usual therapies for *Virombo* possession. Most cases of discipline in respect of spirit possession occurred at the congregational level; in the

47 Livingstonia Presbytery Minutes, 20 July 1918. MNA 47/LIM/3/21.
48 Livingstonia Presbytery Minutes, 12 July 1929. MNA 47/LIM/3/24.
49 Hokkanen 2004, p. 332.
50 Marwick 1970, p. 75.

Presbytery minutes between 1899 and 1920, there is only one case of "Virambo Activity Suspension" recorded. In May 1914, the Presbytery dealt with the case of Miriam Nyaumana, from the Bandawe session, who

> …being taken ill with Virombo (demon possession) went to a native doctor who gave her "mankhwala" to drink. Later, the woman became an assistant to the native doctor, and administered the "mankhwala" to others.[51]

The Bandawe Session regarded this procedure, a typical pattern of the sufferer becoming a healer,[52] as "a gross return to heathenism" and asked for guidance. The Presbytery discussed the issue, and accepted the motion, proposed by Yafet Gondwe and Andrew Mkochi, that the woman should be suspended "sine die".[53] The CSC was formed during the same Presbytery meeting. *Virombo* cases were of particular importance to the church at the time. According to Ncozana, Livingstonia Mission expelled one hundred and one of its members on the grounds of involvement in spirit possession between 1901 and 1919. This represented eighteen per cent of all cases of expulsion brought before Kirk Sessions during that time. The number of cases increased sharply around 1915, although possession cases were still relatively rare in comparison with the number of beer-drinking and adultery charges considered at the Session.[54]Between 1913 and 1923 a total of nine *Virombo* cases from the Ekwendeni congregation were recorded. In all cases the church members involved were suspended.[55]

Spirit possession, therefore, was one of the main issues behind the discussions in 1915 about "superstitions". J.H. Morrison, a deputy of the Free Church of Scotland who visited Livingstonia in May 1914,[56] provided a revealing account of a debate that took place in the Livingstonia Kirk Session, concerning the censure of a woman who had "engaged in a devil dance to cure the sick":

> A native elder subtly argued that these dances did, in fact, cure the sick, not through any diabolical agency, but through the nervous influence on the patient – a view which the medical members of the Council were not prepared to reject. One felt that casuistry had not perished with the Corinthian Greeks.[57]

In the light of Mission Council and Presbytery Minutes, Morrison's account seems credible notwithstanding its paternalistic tone. Morrison was in Livingstonia for four days.[58] It is not possible to identify the elder quoted in the

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51 Livingstonia Presbytery Minutes, 15 May 1914. MNA 47/LIM/3/21.
52 This pattern is typical of the widespread *Ngoma* phenomenon in Sub-Saharan Africa, which Janzen has analysed as a discourse of healing where drumming, dancing, and the transformation of sufferer into healer are central. Janzen 1992.
53 Livingstonia Presbytery Minutes, 15 May 1914. MNA 47/LIM/3/21.
54 Ncozana 2002, pp. 150-151.
55 Ekwendeni Congregation Minute Book 1913-1938. MNA 47/LIM/3/5. (Cases compiled and translated by G.W. Kayira)
56 Minutes of the Mission Council, 13 May 1914. MNA 47/LIM/3/17.
57 Morrison 1919, p. 47.
58 Laws to Daly 27 May 1914. MNA 47/LIM/1/1/14, 183.

case, but he certainly used the missionaries' own psychological and neurological theories to justify a local form of therapy.[59] The Livingstonia doctors – who themselves had provided a psychological explanation of the fear of the supernatural as a contributory cause of illness and death[60] – could not credibly dismiss such arguments out of hand on medico-scientific grounds. However, it appears that it was the more moralising, theological ruling that determined the case in the end.

As the missionaries and African converts discussed spirit possession in English, Tumbuka or other vernacular languages, they created a new language through translation and the formulation of concepts. When missionaries referred to spirit possession as being caused by "demons", "devils" or "diabolical agency" they were introducing old Christian English terms to describe Central African phenomena. When used in missionary publications, these terms could evoke a sense of African "darkness" in the Western Christian reader. Furthermore, the existence of Satan and demons was very real to some missionaries, and this could adversely affect their health.[61]

Donald Fraser developed an idiosyncratic approach towards nervous health and religion. At a missionary conference in 1910 he suggested that missionaries should utilise the African belief that spirits caused bodily harm, in order to promote belief in spirits that caused spiritual harm – "demons" in a Christian sense. Spirit possession and divination were commonly interpreted as madness or hysteria. For Fraser, however, the perceived neurotic tendencies of Africans, when properly channelled and controlled, could contribute to genuine and beneficial African religious experience:

> I know that the African is neurotic, few people can be more so, yet I do not see that we must taboo all neurotic tendencies. If he knows himself to be possessed by God and submits this possession to the test of harmony with the revealed will of God I do not see why this should not be a great asset to the church. It has great dangers, but it has also its great powers. It is not the "canny Scot" but the fervid Celt who is most closely allied to the African…[62]

In this respect Fraser adopted a very different position from that of Laws, Elmslie, Innes, Chisholm and Prentice, doctors for whom careful nervous control and discipline were essential to ensure the holistic health of an individual.[63] The scientifically trained missionary doctors could not accept the

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[59] It is noteworthy that in the Institution, the members of the Literary Society had debated the issue of witchcraft. In February 1905 the Society held a symposium on "Witchcraft and Ghosts". A syllabus for the Livingstonia Literary Society, 7th Session, 1905. NLS, Acc. 7548, D 71. Letters to the Livingstonia Sub-Committee 1905, p. 42; Forster 2003, p. 11.

[60] See, for example, Steele to Laws 30 October 1890. NLS, MS. 7894, 77; Livingstone 1921, pp. 364-365.

[61] See Chapter Five. For example, Rev. Jack Martin, appointed to Livingstonia in the early 1920s, believed in the existence of evil spirits. Sinclair 2002, p. 51.

[62] Fraser, "Heathenism", *Report of the Third General Missionary Conference of Nyasaland,* 1910, pp. 30-34.

[63] In his views, Fraser was alone among missionary leaders. In 1924, Mamie Martin noted how Fraser was described as being a "Celtic visionary and unpractical idealist" by many of his colleagues. Martin 28 January 1924. Sinclair 2002, p. 176.

reality or validity of terms such as "spirits" or "demons" in their discussion of disease. The languages of religion and medicine could not be easily reconciled, in this case. For Western medicine, "demons" did not exist, but "nervous influences" were very real. The educated African Christian elite did not fail to see the inconsistency, and tried to reason with the leading missionaries using the language of Western science and medicine.

The Presbytery and Kirk Sessions were forums of debate open only to men. Women were disciplined for spirit possession more often than men. It has been argued that spirit possession, which became more common in the region during the 1910s, was connected to labour migration and the absence of men from their homes. In the 1920s, as many as seventy per cent of the Tumbuka men were away from their home villages at any one time, with some men being absent for ten years or more. Women in village communities were, therefore, under increasing emotional and material strain. Leroy Vail and Landeg White have argued that the history of the *Vimbuza* spirit possession complex (including *Vimbuza, Virombo* and *Vyanusi*) should be understood in this context.

During the decades before the First World War, spirit possession had been an experience of both Tumbuka men and women. The nineteenth-century culture of possession seemed largely to be a form of protest against Ngoni rule. By the 1920s, however, the social, political and economic position of Tumbuka men had improved as a result of labour migration and mission education. Men had greater control over money, cattle and land, and they were no longer subordinated by the Ngoni elite. In contrast, the socio-economic position of Tumbuka women had worsened, and the increased number of possession cases among women reflected this development. In Vail and White's words, the Tumbuka women "used the licensed voices of the spirits as a way of seeking a measure of spiritual power and as an avenue of protest". During the 1910s and 1920s, the *Vimbuza* possession became more prevalent and was an almost exclusively female experience. Furthermore, Christian and non-Christian women were possessed. As such, spirit possession was a matter of concern not only for missionaries, but also for the African Christian elite. The leading Christians and the Ngoni chiefs expressed their agreement with the missionaries over the condemnation of *Vimbuza* as immoral and contrary to both Christian values and the traditional order. Following their appeals, the colonial authorities outlawed *Vimbuza* in 1924, but failed to enforce this ban.

Beyond the colonial state's failure to control *Vimbuza*, Vail and White have argued that the spirit possession complex persisted in Tumbuka society because it offered a way to address fears of witchcraft within society after public witchcraft accusations and the poison ordeal had been outlawed by the British. Furthermore, in the heterogeneous Christian culture that developed in the region during the 1920s and 1930s, a variety of churches were founded which, unlike the official Presbyterian Church, tolerated spirit possession. Vail and White have also discussed how *Vimbuza* songs offered women a way of representing and maintaining their view of history. These songs represented an idealised vision of the past in matrilineal Tumbuka societies before the Ngoni

invasion, the imposition of colonial rule and the establishment of a capitalist economy – all of which marginalised women. For all of these reasons, the spirit possession complex is still important for Tumbuka women.[64]

The poison ordeal, abortion and Ngonde post-mortem

The Livingstonia Presbytery also ruled upon cases that related to local theories of disease causation and the discovery of individuals responsible for the "diseases of Man". The poison ordeal, as discussed above, was one practice that the medical missionaries attacked with particular ferocity from the outset. This attitude remained prevalent in the Presbytery. In 1913, a woman from the Bandawe Kirk Session was excommunicated after giving *mwavi* to a dog in order to cleanse herself from blame "in a case in which she was implicated". At the same meeting another woman from Bandawe was excommunicated on the grounds of "concealment of pregnancy and abortion". This was regarded as a sin of "a very serious nature".[65] Although there is no mention of the use of medicines in this case, various local medicines were often used to induce an abortion.[66] There is little doubt that these would be classified as "bad medicines" by the church.

In 1915, the Karonga Kirk Session requested clarification over whether or not a Christian who took part in a "native post mortem" could be charged and disciplined. The unanimous ruling of the Presbytery was that since the reason for the post-mortem was merely to find out the cause of death and there was no discernible connection with any form of witchcraft, in this case there could be no grounds for a charge. The missionaries were apparently not aware that one of the key functions of the Ngonde post-mortem was to discover whether or not witchcraft was involved in the death.[67]

11.3 "Dig for your medicine and mix it with God."[68] Church leaders and local therapies

Cases in Loudon, 1908-1926

The discussions of illness and health in local Kirk Sessions and congregations merit further analysis. Loudon was the largest Livingstonia congregation of the

64 Vail and White 1991, pp. 231- 243.
65 Livingstonia Presbytery Minutes, 21 August 1913. MNA 47/LIM/3/21.
66 Young 1931, pp. 89-90.
67 Livingstonia Presbytery Minutes, 28 August 1915. MNA 47/LIM/3/21; Mackenzie 1925, pp. 284-285.
68 An African proverb, translated and quoted by Alexander Dewar from Karonga in 1903. Dewar 10 August 1903. NLS, Acc. 7548, D 70. Letters to the Livingstonia Sub-Committee, p. 114.

time, making it a promising case-study.[69] The following analysis is based on a sample study of the Loudon congregational records in Tumbuka – minutes of elders (1908–12), the Session records (1910–28), and the Congregational minutes (1915–21).

In 1908 Donald Fraser established a system of sub-Sessions across the vast Loudon district. The district was divided into a dozen parishes, each controlled by a sub-Session consisting of an evangelist, elders and deacons. The sub-Sessions had the authority to suspend and restore hearers and catechumens, but cases involving church members would be referred to the main Session at Loudon.[70] Between 1908 and 1912, according to the Elder's Minute Book, the elders of Loudon dealt with cases of: polygamy, beer-drinking and brewing, adultery, fornication, divorce, *mwavi*, *Virombo* ceremonies, and widow inheritance. After complaints and charges were made, the elders examined the cases, which usually resulted in the temporary suspension of those found to be guilty. When compared to cases of disciplinary action taken against polygamy, beer-drinking and adultery – which of course could also be health issues[71]– the *mwavi* and *Virombo* cases were rare, and were raised only once according to the minutes.

The *mwavi* case was clear-cut: a Christian was condemned and suspended from the church after it was discovered that he had administered *mwavi*. The *Virombo* case required more investigation, and while the elders stressed that they believed that the disease called *Virombo* was not a result of spirit possession and therefore could not be cured by an exorcism ceremony, they did discover that the accusations made against a Christian for taking part in such ceremonies were "mere allegations".[72] Only three detailed cases that concerned the use of medicines were brought before the Session between 1910 and 1916. In 1911, a man was suspended on the grounds that he tried to force his wife to take medicines to induce abortion. His wife refused. The man was subsequently suspended from the church.[73] In 1918, a Christian woman was alleged to have taken medicines that caused her to abort her foetus. She was reprimanded by the Session and she was suspended indefinitely.[74]

A church member was suspended in 1911 after consulting an *ng'anga* in a judicial dispute. In 1913, it was reported that a Christian man had become mentally disturbed: he had started to spot people as *mfiti,* causing tensions in

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69 Thompson 1995, pp. 151-161. Material relating to Loudon provides a continuous record for a lengthy period. In addition, the writings of Donald Fraser, the missionary-in-charge for most of this period, are valuable for this analysis.

70 Ibid., pp. 161-162.

71 While there were, in the Scottish mind, medico-moral aspects to both beer-drinking and sexual promiscuity, it should be noted that in Central African thought, adultery was a crime which could result in illness and death. Fields 1985, p. 81. Thus, the church authorities were dealing with community health in the wider sense when disciplining members.

72 Loudon Elder's Minute Book, 1908-1912. MNA 47/LIM/3/53. (Transl. by Gift Kayira)

73 Loudon Session Records, 1910-1916, Vol. 2. MNA 47/LIM/3/39. (Transl. by Gift Kayira)

74 Loudon Congregational Minute Book, 1915-1921. MNA 47/LIM/3/40. (Transl. by Gift Kayira)

the community. His relatives had resorted to *Vyanusi* to treat him. Upon hearing about the case, the Session suspended the man, but did not comment upon the actions of his relatives.[75] In another case of "witch-hunting", in 1922, a Christian was suspended after having accused someone of causing his sister's death. This man claimed to have known exactly who killed his sister, even though he apparently had little tangible evidence. Therefore, the Session concluded that he must have been involved in a witch-hunt, and disciplined him. It seems that the accused did not openly speak about witchcraft, but that he did discuss killing, however, it is unclear whether or not he suggested that poison had been used to kill his sister.[76]

In 1916, one member was suspended after dancing a *Virombo* dance.[77] The congregational minutes for the period 1915-21 mention further cases of discipline relating to spirit possession. There were five cases of Christians taking part in v*irombo* dances, two *vyanusi* cases and one case of participation in *vimbuza* dance. Some of the accused were suspended immediately, while others were forwarded to the Kirk Session for a ruling on their punishment.[78] During the period 1918-26, the session dealt with three cases of *vimbuza* and four cases of *Virombo*. In all of these cases, those involved were strongly reprimanded, but were not suspended. The case of Fanny Chisambi is particularly revealing. In 1922, she was discovered to be a *Virombo ng'anga*, and was accused of beating her drums all night. An evangelist and an elder went to her and warned her about her *kwanga* (sin), and she promised to stop. She was then brought before the Session, where she was reprimanded again. She again promised to stop her practice, and was not suspended.[79]

Loudon Kirk Session was chaired by Donald Fraser in 1908-14, 1915-20 and 1923-25.[80] Fraser, as discussed earlier, developed a psychological approach towards African healing. In all probability, it was Fraser who formulated the Session's statement on the "mentally disturbed" witch-finding Christian. However, it appears that in this case someone claiming to be a witch-finder was subjected to *Vyanusi* therapy, suggesting that it was believed that he had been possessed by the spirit of a deceased witch-finder.[81] Alleged witch-finders could find themselves accused of witchcraft, either in a traditional or in a colonial sense; this situation was comparable to that of early Christian converts who could fight the local witch-finders only to end up accused of witchcraft themselves.

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75 Loudon Session Records, 1910-1916, Vol. 2. MNA 47/LIM/3/39. (Transl. by Gift Kayira)

76 Loudon Congregational Session Minute Book, 1917-1928. MNA 47/LIM/3/41. (Transl. by Gift Kayira)

77 Ibid.

78 London Congregational Minute Book, 1915-1921. MNA 47/LIM/3/40. (Transl. by Gift Kayira)

79 Loudon Congregation Session Minute Book, 1917-1928. MNA 47/LIM/3/41. (Transl. by Gift Kayira)

80 Thompson 1995, pp. 131-171, 180-181,196.

81 Cf. Vail and White 1991, p. 239.

The surveillance of the Christian community and the investigation of alleged misdemeanours depended on the elders and their network of informants. The spirit possession dances surfaced relatively frequently because they involved several people and were easier to discover than individual transactions in medicine. Furthermore, belief in spirit possession was problematic for the church because of its religious aspects. The New Testament provides accounts of the healing activities of Jesus and the Apostles, including cases in which evil spirits are driven away. Significantly, although the use of magic is condemned in the Bible, the use of medicines is not prohibited as such. As McCracken has noted, early Livingstonia elders were largely "men of one book – the Book", and their knowledge of the Bible was extensive.[82]

In Loudon, there were only a few cases of disciplinary action taken against church members who had consulted local medical practitioners. During this period there were just two documented cases relating to the use of medicines to induce abortion, and one case of a Christian resorting to divination in order to dispute a criminal charge. Although divination was unacceptable in the eyes of the church, it was difficult to identify those who resorted to local divination practices. It was sometimes easier to turn a blind eye than alert the Session and the missionary. It also seems that during the 1920s the Session's attitude *vimbuza* and *vyanusi* became more lenient. Of the eight cases discussed in the Session between 1919 and 1926, all of the accused church members were reprimanded and warned not to get involved in such activities again, but none were suspended. Fraser recognised that many African therapies, including possession dances, addressed issues that missionary medicine could not answer, suggesting that the missionary-in-charge had also become more tolerant by the early 1920s. In contrast, in the Ekwendeni congregation – where the prominent missionary was Walter Elmslie, who had notably harsh attitudes towards African medicine in general and spirit possession in particular – in all nine cases of *Virombo* charges, dealt with in the Session between 1913 and 1923, the accused church members were suspended.[83]

Thompson has argued that despite the differences between the traditional Ngoni courts and the Kirk Sessions, both bodies fulfilled a similar, important function: they were instrumental in the restoration of social harmony, which in the case of the Sessions depended on both the suspension and the restoration of members. It is significant that in Loudon, church members were more often restored than in most other Livingstonia sessions.[84] This seems to have been the case with personal and public health issues such as spirit possession and the use of local medicines. The restoration of social harmony was in itself crucial to community health in Central African theories of illness and, thus, the Sessions could be regarded as performing an important public health function even

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82 McCracken 2000, p. 296.

83 Ekwendeni Congregation Minute Book, 1913-1938. MNA 47/LIM/3/5. (Transl. by Gift Kayira) Thompson has noted how Fraser from the beginning of his missionary career preferred shorter periods of suspension and more frequent restorations to church membership than his older colleagues. Thompson 1995, p. 86.

84 Thompson 1995, p. 159.

when discussing cases that were not explicitly related to health or illness. Furthermore, while both beer-drinking and sexual promiscuity had, in the Victorian Scottish mind, medico-moral aspects, it is also significant that in Central African thought, adultery was a moral transgression which could result in illness and death.[85] In this way, the church authorities were dealing with community health in a broad sense when they disciplined members.

Spiritual healing in Karonga

The Presbytery rulings of 1915 and 1916 on "Charms and Superstitions", then, provided justification for the condemnation of various African practices, while in practice allowing some flexibility to African church leaders when dealing with their congregations. This was a potential source of conflict, which became particularly acute during the late 1920s and early 1930s. Between 1920 and 1930, a wave of spirit possession cases occurred within the church, highlighted by the emergence of several "miracle workers".[86] These people claimed to have the power to heal the sick and perform miracles, because they had been possessed by the Holy Spirit. In this way, they combined elements of African healing with Christian tradition in a way that was rejected by most missionaries, particularly medical missionaries. Spiritual healing and Western medicine were increasingly difficult to reconcile in the late nineteenth and early twentieth century, as Terence Ranger has noted.[87]

In the Karonga district, Lameck Chirongo, a Christian convert from the Buyombe congregation, toured the villages curing the sick and administering medicines to treat disease and to deal with witchcraft. George Nyasulu – a former member of the CSC and distinguished evangelist in the former German territories, now a local evangelist at Buyombe – was convinced that Chirongo, called *"Mzimu"* had a genuine gift of healing. When the activities of Chirongo were reported to the Karonga Session, Nyasulu was accused of collaborating with Chirongo and recommending him to many other Christians. The missionary in Karonga, Rev. Faulds, pressed for Nyasulu to be questioned. Nyasulu, who argued that the matter had already been discussed and resolved outside the congregation, testified that he had indeed seen Chirongo heal an epileptic child who was thought to be dead and that he had described what he had witnessed to people from Nthalire and Mpata. In November 1930, after a lengthy discussion, the Session came to the conclusion that Nyasulu had not actually advised people to pray to Chirongo for spiritual healing, and the allegations were dismissed.[88] In the Session's opinion, the fact that Nyasulu

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85 See, for example, Fields 1985, p. 81; Fraser 1922, pp. 145-146.
86 Ncozana 2002, p. 153.
87 Ranger 1981; Ranger 1982.
88 Karonga Congregation Minutes 29 November 1930. MNA 47/LIM/3/11 (transl. by G.W. Kayira); Ncozana 2002, p. 153. After the First World War, Nyasulu had worked independently as an evangelist in the Tanganyika Territories, based in Bulongwa in 1923. See Brown, quoted in *Other Lands,* October 1923, pp. 35-36.

believed that Chirongo healed people and said so was not, in itself, a problem. However, if he had instructed people to pray to Chirongo, that would have been deemed unacceptable. Faulds was the only European in this Session, which boasted seventeen layman members and was chaired by Rev. A.B. Mwakasungula. Local decision-making lay firmly in African hands in the Karonga congregation by this time. Furthermore, Nyasulu's retort to Faulds that the issue had already been settled outside the congregation highlights the fact that local Christians solved problems and accusations by themselves without ever coming under the notice of the European missionary.[89] After the war, Nyasulu had supervised the parishes in the Livingstone Range in the former German territory, working successfully, as Marcia Wright has noted, "with a very lively religious situation with only periodic European backing".[90] Nyasulu had coped with a religious atmosphere marked by both a spiritual Christian movement and an emergence of a popular local prophetess at a time when there were no European doctors or ministers to available supervise or to assist him. Such an experience would arguably foster tolerance and pluralism in matters of illness and health.

However, the Presbytery took up the case almost two years later. In July 1932, Nyasulu's name was removed from the list of candidates for the theological course at the Institution, and the Karonga Session was instructed to investigate his case and discipline him if necessary. This motion was put forward by MacAlpine, seconded by Rev. Yesaya Chibambo, and was carried against an amendment by Levi Mzuma and William Mkandawire, who proposed that Nyasulu should be admitted to the course.[91]

The Karonga Session duly reported that Nyasulu had met Chirongo and recommended him to people as a "miracle-worker", but he was not suspended and the Session requested that he be allowed to continue his work as an evangelist. Rev. Edward Boti Manda proposed a motion that the Karonga Session should be *"strongly reprimanded for disobeying Presby's decision for not suspending Nyasulu"* but after this reprimand, their request should be granted. Manda's motion was carried against an amendment by Rev. Dr Burnett and Yesaya Chibambo, who wanted to have the case referred back to Karonga, and suspend Nyasulu. Manda's proposal won, by a majority of three votes.[92]

Ncozana has interpreted Nyasulu's case as evidence of a changing balance of power in the Presbytery and the church, and argued that the local church leaders, who now had an overwhelming majority in the Presbytery, resolved the case in Nyasulu's favour, while the missionaries would have disciplined

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89 In 1921, it was reported that Karonga had been without a resident missionary since 1915, and African pastor in charge was "working away very bravely". *Report on Foreign Missions for 1921*, pp. 38-40. The district had suffered heavily during the war, including outbreaks of plague, influenza as well as the spreading of venereal disease.

90 Wright 1971, pp. 154-155.

91 Livingstonia Presbytery Minutes 26 July 1932. MNA 47/LIM/3/25; McCracken 2000, p. 297; Ncozana 2002, p. 153. Nyasulu had started the theology course as early as in 1913, but war and evangelistic work in Tanganyika had interrupted his studies.

92 Livingstonia Presbytery Minutes 22 October 1932. MNA 47/LIM/3/25.

him.[93] It is clear that the missionaries were a minority in this Presbytery: in July 1932, there were twelve missionaries and close to eighty African elders and ministers, while in October there were four missionaries and forty-three pastors and elders.[94] Assuming all members voted in October the vote was twenty-five in favour twenty-two against. This means that the issue split the Presbytery down the middle and cannot simply be interpreted as a case of missionaries versus African churchmen. However, the fact that missionary authority in the Presbytery was much weaker in the 1930s than it was in 1910 cannot be disputed. Apart from declining numbers, changes in missionary personnel were also significant. By 1932, MacAlpine was almost the only remaining pioneer missionary; Laws, Elmslie, Fraser and Prentice were all gone.[95] Most of the missionary ministers had no medical degree and the new recruits had probably little knowledge of African medical culture.

Ncozana has interpreted Chirongo's activities as an attempt to Christianise the possession method of healing, drawing on both the Christian idea of healing powers granted through the Holy Spirit and the indigenous Tumbuka medico-religious concept of healing through spirit possession.[96] This seems plausible, although it is difficult to analyse Chirongo's healing activities in detail from the written records. This case and in particular the dispute over the evangelist Nyasulu's role has to be understood in the context of the struggles, contests and negotiation over who determines what was "healthy" and what was "unhealthy" for the Christian community.

E.B. Manda's role is again remarkable. He had been prominent in the discussions about "Charms and Superstitions" twenty years earlier and, like Nyasulu, had been a member of the CSC. Now he successfully proposed that Nyasulu was not to be suspended, though the Karonga Session was reprimanded for its stubborn refusal to heed the Presbytery's recommendations. Manda's proposal was consistent with his earlier attempts to emphasise the independence of the Kirk Sessions to determine which local customs and practices were allowed and which were "superstitions" objectionable to Christians. As McCracken has noted, Manda was a radical pastor who had independent political aspirations before the First World War.[97] His views on African medical culture should be understood in this context.

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93 Ncozana 2002, pp. 153-154.

94 Livingstonia Presbytery Minutes 26 July and 22 October 1932. MNA 47/LIM/3/25. Ncozana gives slightly erroneous figures for the Presbytery discussing Nyasulu's case and does not date it exactly; his narrative suggests it occurred "between 1920 and 1930".

95 Thompson 1995, p. 226.

96 Ncozana 2002, pp. 153-154. A later reference to the "Mzimu of Buyombe" in the Presbytery minutes is from July 1933. Then the Presbytery was glad to recognise that Chirongo, *"who had misled many Christian people by pretending to have supernatural powers"* was now applying for a restoration to church membership. It was recommended that the Buyombe Session and the Presbytery should be assured of his repentance before restoring him. Livingstonia Presbytery Minutes 17 July 1933. MNA 47/LIM/3/25.

97 McCracken 2000, p. 194.

Another prominent Christian of the period, Yesaya Chibambo of Ekwendeni, in 1921 wrote a strong critique of missionaries' policies and attitudes, and in particular condemned the lack of negotiation and discussion between the missionaries and leading African Christians. Demanding African representation on the Mission Council, Chibambo argued that *"uplift and improvement of the native"* could be far more successfully achieved if *"the mind of the native and of the missionary are working and designing together. The members of the Mission Council belong to one race, and are apt to have to same inclination or bias in judging things – i.e. European way of thinking."*[98] Like the missionaries, Chibambo believed that there were distinct "African" and "European" ways of thinking, but he held that these could be "harmonized" if there was equal, balanced and mutually respectful dialogue. Although Chibambo's demands were not met, African Christians were increasingly able to challenge missionary hegemonic aspirations in the 1920s, both directly in the Kirk Sessions and the Presbytery, and indirectly by ignoring missionary views and settling local matters themselves without missionary involvement.

Churchmen and "medicine drinking"

Another revealing discussion in this respect was the debate over the use of "Phemba" medicine in the early 1930s. This medicine was used as protection against poisoning and witchcraft and could be classified as a "charm" although it was ingested and not worn. The Livingstonia Kirk Session enquired about this medicine in 1932, asking, *"Is it right for a Christian to use charms as a protection against poisoning?"* For MacAlpine, it was self-evident that Phemba was a "charm" and a practice contrary to the Word and that all Christians using them should be suspended.[99]

What made this case particularly significant was that, among others, Rev. Y.M. Mkandawire, a Christian minister from the Hara Session, was accused of using Phemba. He was reported as having taken this medicine *"in order that he may escape from being poisoned."* He was suspended while a committee was appointed to investigate the case. This committee consisted of Reverends Galbraith, E.B. Manda, Wm. Mkandawire, John Msowoya and Elijah Nkhoma. They reported to the Presbytery in October 1932 that Phemba medicine was indeed "an evil practice". In a further discussion, Dr Turner moved (seconded by Mateu Banda) that Mkandawire should be deposed from his ministry and suspended from the church. Reverends Ziwa and Mkochi proposed a more lenient amendment, arguing that because Mkandawire had taken Phemba "in sheer ignorance" he should only be severely reprimanded. Ziwa and Mkochi stressed that the Hara Session had also petitioned for forgiveness for the

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98 Copy of letter of Yesaya M. Chibambo to the Mission Council. Minutes of the Mission Council, 21 July 1921. MNA 47/LIM/3/17.

99 Livingstonia Presbytery Minutes 26 July 1932. MNA 47/LIM/3/25; McCracken 2000, pp. 328-329.

reverend. After a vote, Mkandawire was ultimately deposed and suspended, with a clear majority of twenty-five votes cast in favour of Turner's motion.[100]

The case of Phemba medicine was particularly controversial, because like "miracle workers", it was a new term and thus a phenomenon that did not clearly fall within the earlier definitions outlined by the CSC. For MacAlpine the case was clear-cut, but for African Christians it was not at all obvious that a new medicine was necessarily contrary to the Word of God. Phemba was a substance that was ingested, and as such, it could be classified as an acceptable medicine rather than an objectionable "charm". However, as an imbibed anti-witchcraft substance it bore some resemblance to the *mwavi* poison ordeal, which had been the predominant pre-colonial method of dealing with witchcraft, and which had been forbidden by the churches and the colonial authorities alike. Nevertheless, it was "medicine" or a "charm", rather than an ordeal. The reverends and other members of the educated elite could not easily find a clear precedent in the Bible for such a case. It is significant that in the Presbytery minutes, Phemba is constantly referred to as medicine taken "against poisoning".[101] This was the language used in church meetings, allowing a discussion about something that could also be called a protection against witchcraft, a problem that the official church and missionary medicine were unable to cope with. Unlike the Presbytery, the Hara Session wanted to be tolerant. They pleaded the case for forgiveness for a minister who had erred. This time, however, not only the missionaries but also a clear majority of local churchmen condemned the medicine and Mkandawire's action.

"Phemba drinking" was one of the cleansing "drink movements" that concerned the missions and the churches in the Malawi region during the early 1930s, the most famous of which was Mchape: in 1933 the Mchape movement caused Dr Burnett to suspend three hundred and sixty-five church members and catechumens in the Bandawe area. The same year, Yesaya Chibambo reported from uNgoni that drink movements had been a particular problem in Ekwendeni, Hara, and Mlole, but that most of those at Hara who had been suspended for Phemba drinking had been restored.[102] However, Rev. Mkandawire's connection to the Livingstonia Mission and the CCAP was broken. A month after his suspension, he had established a seceding church, the African Reformed Presbyterian Church in the Deep Bay area.[103] In this case, a dispute over the use of medicines seems to have played a central role in the

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100 Livingstonia Presbytery Minutes 28 July; 22 October 1932. MNA 47/LIM/3/25; Thompson 1995, pp. 223-226. Thompson has regarded the suspension of Mkandawire as being particularly harsh in the light of his previously untarnished record and the prevailing need for anti-witchcraft measures. It should be noted that, in this case, the condemnation of the reverend came clearly from both the Scots (including medical missionary Turner) and the clear majority of African leaders.

101 Ranger and Fields have noted how a villager in Tanzania listed poisoning separately among the ills to be cured by the anti-witchcraft antidote *mucapi* (Mchape). Fields 1985, p. 82, quoting Ranger 1973, p. 2.

102 Livingstonia Presbytery Minutes 17 July 1933. MNA 47/LIM/3/25. The wide-ranging Mchape movement has been extensively studied (see Ranger 1973, Fields 1985, pp. 78-90) and is beyond the scope of this study.

103 McCracken 2000, p. 322.

break-up, and the formation of a new church, with an independent policy on the issues of sickness and health at a time when various old and new methods of witch-finding and witchcraft eradication were becoming increasingly prevalent.[104]

Church leaders and African medicine

Local Christian elites, reverends, evangelists and elders exercised notable autonomy in their congregations over the issues of sickness and health. In part, this was because the missionaries had no effective methods of surveillance over the whole of the vast Livingstonia sphere of work, especially during and since the First World War. Moreover, by this time many missionaries had also recognised the value of some African therapies and concentrated their efforts on attacking those practices that they considered to be religiously unacceptable, including forms of spirit-possession. Furthermore, the debates and resolutions of the Presbytery allowed for flexibility within local congregations, if only because many therapies were not named and specifically forbidden. The missionaries had no control over the language and terminology of illness and health, and could only try to prohibit specific practices if they came to their attention.

Oral testimony and tradition sheds further light on the quests for health at a local level. According to S.M. (b. 1907) – who knew the early African reverends including Andrew Mkochi and Charles Chinula in uNgoni – the early churchmen were very familiar with local therapies, and had knowledge of local medicines. They often worked away from the few mission hospitals and dispensaries and had, by necessity, to look after the physical as well as the spiritual health of their flock. They had some European medicines from the mission, and were able to treat minor cases. They also dug up roots to treat coughs, pneumonia and other ailments. Both Mkochi and Chinula were renowned for their wide repertoire of medicines. As previously noted, however, the reverends were generally regarded to be distinct from the *wang'anga*, the indigenous healers, and the reverends did not apparently administer medicines with prayer. This was in contrast to the practices of the *vimbuza* healers, who frequently combined their therapy with a prayer to God. When Chinula broke away from Livingstonia in the early 1930s, he no longer had access to the mission pharmacy, but managed to obtain medicines from the government.[105] Chinula (1885-1970) is still remembered as a great preacher, whose style emphasised death and destruction as well as conversion and salvation.[106]

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104 Ibid., pp. 328-330; Thompson 1995, pp. 228-229.

105 Oral testimony, S.M., 12 July 2004. Chinula formed his own church in 1934, after being deposed from the ministry in 1931, following his confession of adultery. Thompson 1995, pp. 224-225. In Northern Ngoniland, there were mission hospitals established at Ekwendeni (1908) and Loudon (1903), and in the 1920s, a small Government hospital at Mzimba.

106 Oral testimony, S.M., 12 July 2004. Biographical Note on Rev. Charles Chidongo Chinula, MNA Historical Manuscripts Inventory ACC 20; Cook 1975, p. 103.

E.B. Manda wrote to Laws in 1913 and requested medicine for Paulos Msiska. Laws declined his request, responding that since Msiska had been a patient in Ngoniland for four months, he should get medicine from either Elmslie or Agnes Fraser.[107] It seems plausible that Manda had in fact been treating Msiska and requested medicines directly from Laws without consulting either Elmslie or Fraser. Sometimes, however, missionaries did send medicines to Christians in distant villages. In 1917, for example, Laws sent quinine to Soloman Tiyani, a school inspector whose wife had been suffering from fever. Laws instructed him to administer half a tabloid each morning and evening.[108]

As the influenza pandemic spread during early 1919, Laws began to send medicines *"to our teachers and reliable persons in more distant villages where there are sick, and have lads visiting the villages nearby and carrying out the treatment I prescribe."*[109] Perhaps these were exceptional cases during war-time or an epidemic, while there was an acute health crisis in the region. Missionaries were often personally unable to help the widespread Christian community beyond their stations, and under these circumstances it was not possible to demand that that patients travel the long distance to the hospitals. Providing medicines, as Whyte and van der Geest have noted, is a form of therapy that can give the patient notable independence from the healer, in contrast to surgical practice or spirit possession therapy, for example. The power of medicines is independent of the healer providing them.[110] When medicines are prescribed or sent to someone beyond the doctor's reach, they become an independent resource for the patient. For a long time, only missionaries could provide Western medicines in Northern Malawi, but during the 1920s government drugs sales were slowly increasing. In 1927 it was reported in 1927 that apart from tablets of quinine bihydrochloride – which were expensive, sold in bottles of one hundred, and mainly for European use – packets of three, five-grain sachets of powdered quinine sulphate "for native use" were sold in all of the post offices in the Protectorate, at the price of one penny a packet.[111] It is likely that most of the Africans who bought European drugs were mission-educated people who were familiar with quinine and who could afford it.

The members of the Christian elite, individual converts and families acted as intermediaries between missionary medicine and the people, and acted as "refereeing agents" for the mission hospital or dispensary.[112] However, these men and women also actively took part in local medical provision and therapy

Chinula's catch-phrases included, *"Zanga, zanga…bakundonda!!"*(come/convert, come/convert...people are dying in large numbers!). Chinula was also a prominent member and secretary of the Mombera Native Association in the 1920s and 1930s, as well as principal adviser to paramount chief M'mbelwa II from 1929 to 1959.

107 Laws to Manda 24 November 1913. MNA 47/LIM/1/1/15, 471.

108 Laws to Tiyani 8 March 1917. MNA 47/LIM/1/1/17, 900.

109 Laws to Acting Chief Secretary, Zomba, 24 January 1919. MNA 47/LIM/1/1/18, 32.

110 Whyte and van der Geest 1988, pp. 3-5.

111 Nyasaland Annual Medical Report for 1927; MNA S1/1005/28. During the year, 3232 bottles and 833 packets were sold.

112 Oral testimony, P. L. M. and D.C. M., 9 July 2004.

management independently of the mission. The wives of Reverends Peter Thole and Hezekia Twea, for example, had knowledge of local medicines and midwifery, and were often called upon to treat their neighbours.[113] African Christian women from the early twentieth-century Presbyterian Church are conspicuously absent from the written mission records, but there is little doubt that they took an active part in the negotiations over health and therapy within their families and communities. In the Loudon district, Fraser organised a distinct group of women elders, *balalakazi*, responsible for overseeing the spiritual welfare of female Christians. Although this did not become an official mission policy, Thompson has argued that the *balalakazi* in uNgoni strengthened the young church and provided it with female leadership.[114] It seems that they also took an active part in discussions and decisions about illness and health in the Christian community.

There were also attempts to combine both European and African medicines. Rev. Yesaya Chibambo's son recalled how his father told him that some people attempted such mixtures in order to improve the effectiveness of both types of medicine, but with little success. Yesaya Chibambo himself was one of the strongest advocates for mission medicine, and would advise people to go to the Ekwendeni hospital. Chibambo and his wife's commitment to the Ekwendeni hospital was reflected in the fact that his children were among the first to be born there (including Walter (b.1920), named after Elmslie).[115] Yesaya Chibambo, who on other issues such as the status of the African employees of the mission, disagreed profoundly with the missionaries and challenged them openly,[116] seems to have been a "hard-line" champion of mission medicine. In Ekwendeni the prevailing attitude against spirit possession was tougher than in Loudon, and Chibambo was one of those who advocated disciplinary action against Nyasulu in the Karonga case. It seems that in general, however, the attitude towards African medicine even among the Christian elite tended to be tolerant of, or favour medical pluralism.

11.4 Influenza and its aftermath in uNgoni

The global influenza pandemic of 1918-19 was arguably the most lethal epidemic of recent history. It was exceptional, in Ranger's words, in "its intensity, rapidity and unresponsiveness to any form of medication". The disease had reached South Africa by ship in September 1918, and had spread to

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113 Oral testimony, L.H. T., 6 July 2004.

114 Thompson 1995, pp. 162-163.

115 Oral testimony, W.C., 13 July 2004. Yesaya Chibambo was from one of the original Ngoni families who had travelled north. His father had been "a mouthpiece" for the leading chiefs. According to Young, Chibambo combined "impeccable aristocratic connections" with a modernising outlook. See Forster 2003, p. 106.

116 Copy of letter of Chibambo to the Mission Council. Minutes of the Mission Council, 21 July 1921. MNA 47/LIM/3/17; Thompson 1995, pp. 156, 198-200.

Southern Rhodesia by October. Blantyre recorded its first case in November 1918 and Ngoniland, in January 1919.[117]

As Paul Slack has noted, historical epidemics can "throw a peculiarly sharp light on the ideologies and mentalities of the societies they afflicted."[118] Ranger has examined the influenza pandemic in East and Southern Africa as one case that revealed various prophetic responses to pestilence among the religious traditions of Christianity, Islam and African religions. Ranger has stressed the importance of the tensions both within and between these traditions that manifested themselves during times of epidemics and crisis.[119] The disastrous influenza epidemic presented a serious challenge to all existing forms and policies of prevention and cure in Northern Malawi and across Southern and East Africa.

In the annual report for the Mombera District for 1918–19, the Resident at Mzimba first described the arrival of influenza. Upwards of a hundred deaths had been reported at this point. By May 1919, the epidemic had reached Ekwendeni. The Resident tried to make people in the "infected areas" stay in their garden-huts away from the more crowded villages. He also noted, with appreciation, the work of Rev. and Mrs Stuart, missionaries at Ekwendeni, and the Christian teachers, who were helping the sick, administering government drugs, and generally *"assisting greatly in the carrying out of administrative measures to prevent or retard the spread of the disease"*.[120]

At the time, there were only five European households in the whole district. The government was the only large-scale employer of colonial labour. During 1918, the mortality rates among those recruited as military carriers or as migrant labourers to the southern parts of the Protectorate had been high. The Resident admitted that local people were right to point out that people died in much greater numbers in colonial employment in the Protectorate than during long trips to far better paid work in South Africa. There was an outbreak of dysentery in the district following the return of the carriers. Military demands had also resulted in a decrease in the number of cattle, and the prices of commodities like cloth were increasing.[121] Thus, the communities in the district were already under heavy socio-economic pressures and nutrition and general health conditions were poor when influenza arrived.

There was a sharp rise in influenza mortality rates across the district in June 1919. Over four hundred deaths were reported to the Resident during the first fortnight of the month. He estimated that there had been at least a thousand fatalities in the district during that month, although he also noted that it was sometimes difficult to distinguish between influenza and the normal "deaths from chest complaints" which were always common during the cold season. The missionaries provided the government station with influenza vaccine. After demonstrations by the medically-qualified Mrs Fraser and Mrs

117 Ranger 1992, p. 245; Thompson 1995, p. 192.
118 Slack 1992, p. 3.
119 Ranger 1992, pp. 241-243.
120 Mombera District Annual Report for 1918–19. MNA S1/1008/19.
121 Ibid; McCracken 2000, p. 310; Thompson 1995, p. 192.

Stuart, the Resident and his wife vaccinated about fifty permanent colonial staff members. However, he believed that inoculation did not prove to be of "any value whatever" as thirty-six people on the station contracted the disease. Large quantities of medicines were distributed through the Loudon station, its teachers and "reliable headmen & capitaos." [122]

The Resident estimated that there had been over 2,600 influenza deaths in the district during 1919. Fraser later claimed that in Northern Ngoniland, "not a village escaped", and, although the epidemic faded towards the end of the year, its effects were arguably more far-reaching than was suggested by the immediate mortality figures. The Resident, Muggridge, who detailed the activities of the Mzimba government dispensary during 1919 and 1920, believed that all over the district, there was *"an unusual amount of sickness during the rains – probably due to the weakening effects of influenza"*. He argued that long-term neglect of medical provision in the district had left the government helpless in the face of both an epidemic and the ordinary suffering and illness that he considered to be preventable. No government medical officer had been stationed within ten days march of Mzimba. The Resident stressed the value of medicine as an effective means of creating *"warm feelings for personal gratitude amongst the natives"*. This was sorely needed at a time when people complained about sickness and death among colonial labourers and the costs of the war. Muggridge again gave credit to the medical work of Livingstonia, noting with approval that the missionaries *"do it without proselytising to such an extent as to frighten away the unconverted"*.[123] However, it was clear that the medical resources of Ekwendeni and Loudon hospitals, and the small government dispensary at Mzimba, could not provide adequate care for the whole district.

Influenza, Christians and community

Alongside the few missionaries in the district, Christian teachers and active members of the church distinguished themselves by visiting the sick, distributing medicines, giving instructions in hygiene and providing support.[124] The epidemic provoked Christians and non-Christians alike, in uNgoni as elsewhere, to discuss and debate its origins, causes and effective means of prevention and cure.[125]

A personal account of these debates in uNgoni is provided by Levi Mumba. Mumba was born around 1884, was of Ngoni/Senga descent, and was one of the most talented pupils at the Overtoun Institution between 1897 and 1903. In 1902-03 he took a commercial course, taught by Cullen Young. McCracken has regarded Mumba, who was for ten years, until 1915, the senior

122 Monthly Report, Mombera District, June 1919. MNA S1/1140/19.
123 Mombera District Annual Report for 1919/1920. MNA S1/1140/19; Fraser 1923, pp. 103-104. In addition, during the year, the district was plagued by a man-eating lion which was finally shot in March 1920, after reportedly killing over seventy people.
124 Thompson 1995, p. 192.
125 Ranger 1992, p. 245.

clerk at the Institution, to be perhaps the most academically able of the first generation of Livingstonia pupils. After leaving the Institution, he moved into government service, and become a successful civil servant. He was also a notable political organiser, and was prominent in the establishment of the Native Associations as well as in the Nyasaland African Congress in the 1940s. Mumba wrote an essay "The Religion of my Forefathers", published anonymously in the *International Review of Missions* in 1930, sent with comments by Cullen Young.[126] Mumba's father was the spirit cult specialist of his family, and in 1919 both father and son were trying to prevent the spread of the influenza pandemic. Mumba recalled the time of the epidemic:

> We had just moved the village to a new site, and I was with the younger folk at the new settlement. All the people were stricken with the disease. We had received a warning of its coming from the Government, it was not necessary to resort to divining. I was doing all I could to keep the village clean from filth and the people from being attacked by sore throat and pneumonia, but the sickness was rising in intensity. My father was attacked. He approached me, to ask if he could appeal to his ancestral spirits. (He was the family priest, and this was only a matter of courtesy taken in order not to offend the susceptibility of my views, most of which he considered foreign and running counter to family traditions and customs.) I told him I was doing what I could and saw no reason why he should not do the same. One evening he walked with the assistance of a stick to the new village, and stood shaking in front of his chief house with a small cup of beer in his hand. He said: 'Hau kuyuni na?' (Oh, what is the matter?) 'See, all the people in your village are laid up with sickness; there is not one who is able to give the other a cup of water.' He took a sip of beer from the cup and spued [sic] it to the right and then to the left. He grew grave and looking to one side as if he saw the spirits with his human eyes, he continued earnestly: 'Why have you forsaken us? Here is beer – we give you. Look on us compassionately, let the sick get better, peace be on us and on the livestock.' (The prayer for the livestock was for protection from wild beasts.) As it was, we lost no soul from influenza – whether this was in answer to the prayer or not the reader can judge for himself. In the mind of my father, which I share, it showed great faith, and his appeal was effective.[127]

For Mumba, the joint response to the epidemic brought him closer to his father's thought and tradition, with which the Christian convert had previously had conflicts and difficulties. Faith in community health secured by beer sacrifice and prayer to the ancestral spirits, totally unacceptable for the missionaries, was not for Mumba to be condemned when Christian methods of hygiene and medicine failed to stop the spread of the disease. Mumba's tale of his ill father walking to the new village and praying to the spirits has an emotional tone of recognition and reconciliation. By the time Mumba wrote this memoir, he was involved in founding the African National Church (an independent church that upheld polygamy).[128] Of course, his father's side of the story remains untold here.

In comparison, for Christians at Ekwendeni, the influenza epidemic was a crisis that (at least in retrospect) highlighted the value of the medical aid

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126 Typescript notes on Mumba by Cullen Young, MNA 47/LIM/4/16. McCracken 1994; Thompson 1994; Thompson 1995, p. 170.

127 Mumba, "The Religion of my forefathers", typescript [c.1930]. MNA 47/LIM/4/16.

128 MacDonald 1970, p. 110.

provided by the mission. According to one interviewee, those few who appreciated the value of the mission went to the hospital, while the great majority remained in the villages. While there were many deaths in the villages, "those who went to the missionaries got better", which boosted the reputation of Ekwendeni hospital somewhat and was a boon to the reputation of the mission as a whole.[129] This Christian tradition presents the medical mission as a success even at the time of an epidemic, against which Western treatments were largely ineffective. I have found no further evidence to contradict or confirm this view.[130] If there indeed were no influenza deaths at the Ekwendeni hospital in 1919, at the time it could be argued that it was better to go to the mission where people survived than to remain in the villages where people died. In such circumstances, the medical mission could be effective for missionary purposes, even if its biomedical efficiency would seem doubtful to a medical historian.

The *vyanusi* and Christian cleansing, 1920

The evidence discussed above suggests that influenza sometimes brought both Christians and non-Christians closer to each other or highlighted the benevolence and the value of the missionary medicine. However, it is probable that the medical crisis in uNgoni in 1919 also prompted the people to question the value of traditional remedies as well as mission medicine and encouraged novel responses and movements, as was the case elsewhere in Southern Africa. It is significant that in both of the narratives discussed above, the people in the immediate neighbourhood (in Mumba's village and at the mission station at Ekwendeni) survived without fatalities, – albeit with different medical responses – while neighbouring villages suffered. By contrast, in other Southern African rural areas, the mission stations and boarding schools were the places where influenza struck first, with many fatalities. As Ranger has shown, in such cases the reputation of missionary medicine was particularly challenged by the epidemic.[131]

In the Mombera district during 1919 and early 1920, there was a widespread movement of witch-finders, "*vyanusi*", locating the culprits of recent calamities in the villages. Fraser brought this to the Resident's attention and together Fraser and the Resident Muggridge devised a scheme to threaten the witch-finders into giving up their practice. This seemed to succeed to a significant extent in the Loudon area, as described in Chapter 8.

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129 Oral testimony, W.C., 13 July 2004.

130 In Foreign Mission reports for 1919-20, there are limited medical details from Ekwendeni. During both years the station reported the same number of patients, two thousand, which was not exceptionally high. In the Government hospitals of the Protectorate, it was estimated that 11.7 % of admitted influenza patients died. *Reports for Foreign Mission 1919 – 1920.*

131 Ranger 1992, pp. 264-267.

In May 1920 the Resident convicted three people of being professional "*vyanusi*". His report confirms Fraser's account of a large number of people renouncing such practices and handing in their medicines and tools of their trade. The people registered at the Boma, and the three people walking about with "*vyanusi* costumes" after the deadline of 30 April were arrested, and given short sentences (from a fortnight to a month) as an example to others. However, Muggridge believed that the Fraser's anti-vyanusi movement only had influence within the Loudon area, that the most important and influential *vyanusi* had not come forward and that no one dared to inform on *vyanusi*. The Resident approved of the anti-vyanusi movement and encouraged the chiefs of the district to follow their example. He also stressed that in Northern Ngoniland the activity of witch-finders was much less harmful than in the Shire Highlands, and believed that, in general, *"accusations of "ufwiti" are followed by nothing more than unpopularity"*.[132] During July, the Resident described how Elmslie had taken up the anti-vyanusi movement in Ekwendeni and that several people had come to Boma to renounce their craft.[133]

The missionary and the colonial administration reports reveal some new interpretations of *vyanusi* activity and the anti-vyanusi movement as responses to influenza and its aftermath. First, it seems probable that Fraser was correct in his view that the "vyanusi" "multiplied" as a result of the widespread epidemic, when a number of the sufferers who survived became healers, in turn. The pattern of the sufferer becoming a healer after a spending some time in the bush resembles the general description of the *ngoma* type of healing, in which dancing and drumming are central. The name *vyanusi* comes from the chiNgoni word *itshanusi*, meaning witch-smeller, diviner and healer, and this form of spirit possession seems to have developed during the second half of the nineteenth century as a result of interaction between the Ngoni and the Tumbuka. In the missionary and colonial sources, *vyanusi* can refer to both a witch-finder ("smeller") who, according to Cullen Young, could be a local healer in one of his many roles, and to a specific form of spirit possession and the dances and cults involved in possession therapy. As Soko has noted, the successful treatment of a serious *vyanusi* spirit possession case may result in the sufferer becoming a diviner-healer, and this type of pattern was clearly apparent in Northern Malawi in the early twentieth century.[134]

It seems, then, that what the Europeans called the *vyanusi* in 1919-20 could have included a variety of practices including therapy for spirit possession,

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132 Mombera District Monthly Report, May 1920. MNA S1/1140/19. Although in general, Muggridge's official account matches with Fraser's, there are some discrepancies in details. While in Fraser's story, he is registering the renouncing *vyanusi* and the burning of the medicines takes place outside the church, the resident writes of registration taking place in the Boma. Furthermore, Fraser's account of the "old witch-doctor" being arrested *before* registering does not fit in the official chronology. It is of course possible that this person was arrested prior to registration, but the Resident did not report it in detail.

133 Mombera District Monthly Report, July 1920. MNA S1/1140/19.

134 Ncozana 2002, pp. 107-110; Soko 1987; Thompson 1995, pp. 228-229; Young 1931, pp. 28-29.

through which many sufferers became *vyanusi* healers. These healers may have combined old, new and changing practices. As Friedson has pointed out in his anthropological study of present-day Tumbuka healing, *Vyanusi* is now regarded as the spirit of Ngoni warriors, which possesses people and makes them dance in a style of these warriors. Friedson records that one of the surviving *vyanusi* songs praises the remarkable *isanusi*, Mugwede, who according to tradition, in the 1920s outsmarted the British commissioner MacDonald who, like Fraser, tried to expose the "witchdoctors" as fraudsters.[135] The complex connections between dancing, singing, drumming, spirit possession, healing, divination and witchcraft detection escaped the notice of most Europeans who simply called the *vyanusi* healers "witchdoctors". For the Europeans, one way of distinguishing the *vyanusi* was their distinctive clothing, and it was because they wore the *vyanusi* costume that the arrested individuals were discovered.

Secondly, the "anti-vyanusi-movement" masterminded by Fraser seems to have had some impact in the Loudon area, but less so over the whole district. Furthermore, if Muggridge's assessment was correct, the practice of the most famous healers and witch-finders was not affected, their reputation protected them and they remained outside the attention of the few Europeans in the area. In this case, the people giving up their medicines would have been largely ordinary people. They might have been involved in spirit possession therapy, they may have possessed anti-witchcraft medicines (often carried in horns) or they may have had medicines considered harmful (either offensive or defensive) which they chose to give up. All in all, it seems that the *anti-vyanusi* movement was a local cleansing movement where people gave up their potentially harmful and dangerous medicines in response to the epidemic and the subsequent deterioration of general health in the area. The movement cleansed both potential witches and witch-finders, though the missionary language presented them all as quack "witch-doctors" or mentally disturbed "neurotic Africans" wrecked by influenza and scared by charlatans.[136]

Fraser's initiative, then, was successful at a local level largely because it corresponded with the traditional African idea of communal cleansing. In uNgoni this had been the duty of the chiefs who would summon the people to hand in their harmful medicines. The chiefs also had their own anti-witchcraft medicines.[137] In order to ensure its success, the movement required the approval of local leaders, who were approached by both the mission and the administration, in the church as well as in the Boma. The details are missing from the European records, but it can be argued that the leaders of the African Christian community in the Loudon area must have played a significant role in the implementation, if not the planning, of the cleansing scheme credited to

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135 Friedson 1996, pp. 15-17.

136 Thompson has argued that although it is not clear if Fraser distinguished between witches and witch-finders or sorcerers and the doctors, he was aware that the effects of his initiative would be only temporary. For Catholic missionaries as witch-finders among the Southern Ngoni in early century, see Linden 1974, p. 56.

137 Oral testimony, M. M. D. S., 11 July 2004.

Fraser.[138] However, without further recourse to oral tradition, the details of African involvement at this stage remain unclear. From the Resident's report, it seems, however, that chiefs outside the mission centres of Loudon and Ekwendeni were not eager participants of the anti-vyanusi-movement.

Muggridge's notion that the most renowned indigenous practitioners were beyond the reach of the anti-vyanusi-movement suggests that the *vyanusi* practitioners may have mainly been new specialists in the district, possibly itinerant practitioners from other areas. The newly-established Mombera Native Association was concerned with foreign "witch-doctors" rather than with local and established practitioners. In September 1920 the MoNA demanded the suppression of *immigrant* witch-finders.[139] The association represented both the old and the new Ngoni elite, chiefs and church leaders.[140] From their perspective, the troublesome healers in the country were above all travelling witch-finders, who "smelled out" the witches/sorcerers causing illnesses. The MoNA condemned both "witch-finders" and "vimbuza", and especially singled out the travelling witch-finders, who *"profess themselves to be 'vyanusi' i.e. smellers"*. The Association condemned the roving witch-finders who were *"practicing their charms, lots and tricks"*, for causing social unrest, deceiving people, and living in sexual immorality. In contrast, *"good medical men and women"*, should be allowed to practise, *"just exactly as other native doctors, who cause no trouble in the country"*.[141]

It seems, then, that in the turbulent post-war situation, there were an increasing number of travelling witch-finders and medical entrepreneurs in uNgoni who were regarded as a particular threat by the Ngoni leadership. They did not consider the established practitioners in the country to be a problem, but were worried about newcomers whom they, together with the missionaries, may have considered to be "quacks". The condemnation of immoral, trouble-causing quacks combined the interests of the chiefs and the Christian establishment. However, the MoNA would clearly tolerate and accept any new practitioners who proved themselves to be as morally and medically valuable as the established African healers in uNgoni had been. In this light, the cleansing movement of 1920 combined the interests of missionaries, colonial administration, Ngoni chiefs and the local church leaders. Cleansing may have worked both against new practitioners and in favour of the restoration of community health by encouraging ordinary people to renounce their dangerous

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138 Among the prominent Ngoni churchmen of the time were Hezekia Twea and Andrew Mkochi. Thompson 1995, p. 166. Mkochi, together with Daniel Nhlane, had earlier distinguished himself in challenging "witch doctors" as a travelling teacher-evangelist, see Fraser 1925. Fraser himself was forced by ill health to return to Scotland in April 1920 and he did not return to Loudon until late 1923. Thompson 1995, p. 196.

139 Thompson 1995, p. 193.

140 Ibid., pp. 220-223.

141 Minutes of Mombera Native Association, 1920. MNA S1/210/20. The first meeting in September 1920 was presided over by Rev. Hezekia Twea, six chiefs of the Jere clan were present, as well as Rev. Andrew Mkochi and other prominent Christians including Mawelera Tembo, Peter Thole and Yesaya Chibambo. Both Levi Mumba and Charles Chinula became especially influential within the MoNA.

medicines (a function previously performed by chiefs) as well as upholding prevailing order and established medical practice.

However, for those, in uNgoni or elsewhere, who considered the witch-finders and spiritual healers to be more effective than (or even partially effective but more readily available than) Western medicine, a hunt for witch-hunters would be an irrational and dangerous assault on public health. The early 1930s witnessed an increase in the numbers of traditional and new movements that aimed to deal with witchcraft and possession. In Loudon, Jonathan Chirwa reported, in 1931, that even church elders had been connected with *Vimbuza, Virombo, Vyanusi* and *Maura* (a divination/diagnosis technique) practices. The Ngoni paramount invited *Mchape* specialists to the district in subsequent years.[142] For those dissatisfied with the missionary policies and resources, some of the emerging independent African churches offered a more appealing approach to communal health than that offered by the Livingstonia Mission and the Presbyterian Church.

11.5 Independent churchmen and medicine

When Yafet Mkandawire founded his church in 1935, he became one of many former Livingstonia converts, pupils and graduates who had broken their connection with or been expelled from the mission. Many of them became independent churchmen and active members of the various denominations and religious groups which flourished in the Malawi region from the turn of the century onwards. The late 1920s and early 1930s, in particular, were marked by notable secessions from Livingstonia. The factors contributing to this phenomenon have been extensively discussed by McCracken and Thompson.[143] As noted above, it is significant that one of the major reasons for African disillusionment with the Livingstonia Mission at this time was the missionaries' inability to cope with witchcraft which was regarded as a major health issue. However, witchcraft was not the only threat to health that the independent African church leaders had to cope with. A case-study of some of early independent churchmen, whose history is well-documented, provides important insights into variations in the quests for health among African Christians in the early twentieth century. The independent churchmen would have had to devise their own policies and methods for public health and curative therapy. The break with the mission would have meant that those who had previously relied upon missionary medicine would have to look for other resources. Charles Chinula, for example, used government medicines as well as African remedies after leaving Livingstonia. Chinula seems to have had had a wide range of pluralistic medical resources available to him.[144]

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142 Thompson 1995, pp. 228-229.
143 McCracken 2000, pp. 328-331; Thompson 1995, pp. 223-227.
144 Oral testimony, S. M. (b.1907), 12 July 2004.

For those who had access to local therapies, and used missionary dispensaries only occasionally, if at all, the transition to an independent church would not pose major difficulties in their search for health and therapy. Those who had been part of the close-knit circle of the mission from their early childhood and who had little connection with non-Christian communities, missionary medicine would have been the main, if not the sole, source of therapy. This was arguably the case for Charles Domingo.[145] Unfortunately, Domingo's surviving letters do not directly reveal much about his policy about preventive or curative medicine. In his letters, he only briefly mentioned an illness that both he and his family had been suffering from. Considering Domingo's background, it is probable that he would have resorted to Western medicine if possible, but the extent of his knowledge about and his attitude towards African medicine remains open to speculation. According to W.P. Livingstone, when returning to Nyasaland from Scotland in 1910, Laws met Domingo in Blantyre. Domingo was ill, and Laws prescribed medicines for him. Domingo was born outside the Malawi region and raised by the missionaries, and so he probably would not have ready access to local therapeutics. As an independent church leader and head of a family, he would have had to make therapeutic decisions from a particularly difficult position. An approach which emphasised spiritual healing and prayer would suit a Christian with only limited access to medicines. However, Domingo strongly believed in the dual nature of man, the spiritual and the physical, and dismissed "as weak and pointless" the Watchtower doctrine of man as an entirely physical being. This would arguably have led him to emphasise the importance of physical remedies to treat physical ills and shun comprehensive spiritual healing. In his approach to the spirit and the body, Domingo took a notably different approach from that of another talented Livingstonia pupil turned independent church leader, Eliot Kenan Kamwana.[146]

Kamwana, a Tonga born around 1872, was arguably for a short time, the most popular independent religious leader in Northern Malawi. After studying

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145 Daily Journal of Livingstonia Mission, entries for 1881-1882. MNA 47/LIM/10/2.; Livingstone 1921, pp. 194-195; McCracken 2000, p. 79; Rennick 2003, p. 215; Thompson 1995, pp. 167-169. Domingo was the son of a cook employed by the ALC at Quelimane, and was brought to Malawi in 1881 by William Koyi. Laws' patient book shows that he was treated repeatedly by the doctor in the early 1880s. He later became Laws' "dispensary boy" and personal servant. He was trained as a "house boy" by Mrs Laws. In the late 1890s he became one of the first theological students to attend Overtoun Institution. Thus, he had detailed knowledge of missionary medicine and its repertoire, both as a patient and as a dispensary assistant (although he did not apparently receive much formal medical training from Laws). Domingo was among the most successful and talented Overtoun Institution pupils, and became a prominent elder and in 1903, a licentiate preacher, but his ordination was delayed. Following a conflict with Fraser in 1908 in Loudon where Domingo was an assistant minister, he left the mission and founded his own church.

146 Livingstone 1921, p. 339; Domingo 28 November 1913. Chancellor College Library, Malawiana Collection, Domingo Letters, Letter 59. For comparison of Domingo and Kamwana, see McCracken 2000, pp. 254-257. According to McCracken, Domingo was "almost obsessively concerned with remodelling his adopted homeland along "progressive" European lines" – further evidence that he may have been an advocate of Western medicine in Africa.

at the Overtoun Institution between 1898 and 1901, he taught at the mission school at Bandawe, but was suspended on "moral grounds". He subsequently joined Joseph Booth's Seventh Day Adventist Mission, before leaving for South Africa. Between 1904 and 1907, he worked as a hospital assistant at the Main Reef Mines near Johannesburg, during which time he studied the Bible and preached to his fellow migrant workers. According to Chirwa, the harsh conditions and treatment of the workers in the mines radicalised Kamwana's critical attitudes towards European rule. In South Africa he learned of the new Watchtower doctrines of C.T. Russell. Like Domingo, Kamwana had inside knowledge of Western medicine, but his time at the colonial hospital of the mines was a more radicalising experience.[147] Although it is not clear if he condemned European medicine at this time, he would have witnessed African labourers suffering, dying and receiving inadequate medical care.

After his return to Nyasaland in 1908, Kamwana embarked on a highly successful career as a Watchtower preacher. He emphasised belief, repentance and baptism. He preached about the fall of the Babylon – the European mission – and the Beast – the colonial government. Kamwana believed in the ecclesiastical concept of instantaneous conversion, and opposed the Scots' policies of limiting baptism and of church taxation. By April 1909, he had baptised over nine thousand people in the Bandawe area, including several former teachers and pupils at Livingstonia. He presented such a challenge to the mission and the administration that, later in 1909, he was arrested and deported from the country. MacAlpine and Elmslie pressed for Kamwana's arrest by arguing that he threatened to subvert the whole colonial order. After the Chilembwe rising in 1915, Kamwana was deported to the Seychelles for twenty-two years even though he had personally refused to participate in the rising.[148]

It is unclear precisely what role medicine and healing played in Kamwana's early Watchtower movement. It is possible that its emphasis on an imminent Second Coming and life after death could result in less emphasis being placed on curing this-worldly bodily ailments. However, Fields has argued that Kamwana's baptism by immersion could well have been associated with the curing of witchcraft victims and the cleansing of witches, as was the case in the later Watchtower movement. Although there is little direct evidence to confirm that Kamwana or his followers regarded baptism in such terms, the emphasis he placed on baptism and his general success cannot be overlooked. Many of those baptised by Kamwana believed that they had been cleansed from all sin by immersion.[149]

Furthermore, the importance assigned to bodily health and life in Kamwana's movement is highlighted in its attitudes towards bodily death. As

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147 Chirwa 1983; McCracken 2000, pp. 227-231; Rennick 2003, pp. 217-218; The mortality of Central African recruits in South African mines was extraordinarily high between 1903 and 1913, with most dying from pneumonia. Annual mortality commonly exceeded 100 per 1000 during this period. See Packard 1993.

148 Chirwa 1983; Fields 1985, pp. 114-115.

149 Chirwa 1983; Fields 1985, pp. 117-123, 256-257; McCracken 2000, pp. 247-248.

Chirwa has pointed out, Kamwana addressed the issue of life after death in a way that appealed to the Tonga community. The missionaries taught that people would be judged after they die by Jesus but were less clear on the exact nature of the dead – they spoke of souls rather than the bodies of the dead. Kamwana, however, had read a Watchtower pamphlet, "Where are the Dead?" written, incidentally, by a Scottish doctor, Dr John Edgar, Professor of Midwifery at Anderson College, Glasgow. According to Edgar, the dead were in their graves waiting for judgement, and would rise, physically, to attend the final evangelical campaign. In this campaign, the saved would be selected. Kamwana issued copies of Edgar's pamphlet to a close circle of his educated associates, whom he thought would understand its importance. To Kamwana, as McCracken has noted, "belief in millennial solutions was strongly tempered with concern for the physical wellbeing of his people".[150] This strongly suggests that bodily life and well-being were at the heart of Kamwana's movement, along with an expression of protest against the missionaries and colonial rule.

The physical was intertwined with the spiritual in Kamwana's preaching and baptism in a way that appealed to his audience in contrast to the seemingly vague and unclear dualism of the missionaries. Kamwana's supporters were largely disappointed and frustrated with the missionaries, who were seen to withhold their privileges and benefits from the majority. Like many of his contemporaries who challenged missionary authority, Kamwana believed that the missionaries had hidden many written truths,[151] and he could present the writings of Edgar as evidence of this fact. In doing so, Kamwana used the theories of a Scottish doctor to attack the teachings on body, soul and mortality of Livingstonia, one of the most medical of all the Scottish missions.

Kamwana's later history highlights the emphasis he placed on healing in both his thought and action. After being pardoned, he returned to Nyasaland in 1937, and established a new movement, the Mlonda Healing Mission Society or Watchman Healing Mission Society. Significantly, by this point in his career Kamwana explicitly rejected the use of all kinds of medicines, whether African or European. His followers took an oath to abandon all medicines, and accept only prayer in times of illness, although this spiritual healing of Watchmen did not deal with spirit possession. As Chirwa has pointed out, Kamwana's anti-medicine policy was an attack against the European missions' perceived use of Western medicine as a tool of conversion. However, Kamwana also attacked the medical pluralism of African society, and rejected the traditional importance of spirits in healing. His movement was not flexible in its attitudes towards health and healing, and because of this many people lost interest in it.[152] Kamwana's

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150 Chirwa 1983; McCracken 2000, p. 250. In 1922, Rev. Martin in Tongaland was questioned on his teaching regarding resurrection: "How can our bodies be raised if we have been eaten by worms?" Martin 20 September 1922. Sinclair 2002, p. 93.

151 Linden 1974, p. 77.

152 Chirwa 1983, p. 17. Kamwana was apparently generally critical of education and European knowledge from early on. McCracken has noted that Kamwana was not interested in establishing schools. During the Chilembwe Commission enquiry in 1915 Kamwana stated: "Knowledge is power. But [there are] very few who can use knowledge properly for general interest". Quoted in McCracken 2000, p. 255.

later movement can be compared with other anti-medicine movements in Southern and East Africa during the inter-war period.

Kamwana's new movement is largely beyond the scope of this study, but his case demonstrates that mission medicine was sometimes explicitly regarded as a tool for conversion by critical African commentators. Lyons has noted how Western biomedicine was often recognised by the colonized as an influential ideological weapon of the colonizers.[153] As Opp has argued, faith healing can present a serious challenge to medical orthodoxy within the Christian community, and it can be wielded as an effective weapon against medical establishment.[154] However, when Kamwana forbade the use of all medicines, he was in opposition to the pluralistic medical culture of Northern Malawi, which made his movement even less tolerant and flexible than the Presbyterian Church and the Livingstonia Mission.

In some cases, however, it was the limited access to missionary medicine that most aggravated African churchmen. The early teachers, preachers and later reverends, were often sent to remote areas with little or no medicines at all from the missionaries. In 1903, Rev. Dewar described the request of one teacher sent to cold highlands about four thousand feet above Karonga:

> [he] was most anxious to prepare for the coming trying experiences, and wished to take a cough mixture with him. A native proverb says, "Dig for your medicine and mix it with God." He evidently believed in it. We were sorry we could not supply him (for some months we have been handicapped through want of the commonest remedies), so he did perhaps the more sensible thing, he took an extra good blanket with him.[155]

Y.Z. Mwasi, one of the first ordained African ministers at Livingstonia, made this point when he listed his "Essential and paramount reasons for working independently" in 1933. He wrote,

> …from 1907 up to date I have been working alone from the mission station – at a distance of more than 20 or 30 miles…–without a help of a newspaper, medicine or schoolteacher from the mission...[underlines original] In the case of the white missionary himself he depends upon these facilities of medicine and education while in the case of native missionary the white man does exert his best effort to have these influences isolated from him…[156]

It would be an exaggeration and simplification to suggest that a lack of access to mission medicine prompted Mwasi's departure from Livingstonia. His reasons were numerous, but his complaint highlights the fact that those African Christians who sought Western medical aid were often sorely disappointed. Distance prevented many from benefiting from dispensaries and hospitals. In addition, the African clergymen did not enjoy the regular European holidays

153 Lyons 1994, p. 203.
154 Opp 2002.
155 Dewar 10 August 1903. NLS, Acc. 7548, D 70. Letters to the Livingstonia Sub-Committee, p. 114.
156 Y.Z. Mwasi, "My Essential and paramount reasons for working independently" (1933). MNA 84/BCAP/1/a-d.

and changes of location that were seen as essential for maintaining European health. African ministers were allowed only a fortnight's holiday. Laws wrote, in 1920, to Mwasi who had apparently requested a holiday in Blantyre for health reasons. Laws agreed that, *"certainly recreation is good and useful as Solomon says, 'A merry heart doeth good like a medicine' and this is...the secret of all pleasure and recreation as also its guide and measure..."* However, he argued that a visit to Blantyre would take Mwasi away from his congregation in Chintheche for a month, and that would require the Presbytery's permission.[157] In 1929, Mwasi had demanded that African teachers should be provided with "model houses" to set an example to villagers, and that the teachers should not have to depend on the villagers for their food supplies.[158]

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157 Laws to Mwasi 10 June 1920. MNA 47/LIM/1/1/19, Letterbook of Laws, 1919-1921, 705.

158 McCracken 2000, pp. 318-319. During the 1920s the missionaries' salaries averaged ten times of that of African ministers, and difference in standards of living provoked resentment. Cook 1975, p. 104.

12 CONCLUSION

This study has examined missionary, African and colonial quests for health, and experiences of illness and healing in the Malawi region within the framework of the Livingstonia Mission from its inception, through its heyday, to its relative decline in the 1920s. A number of themes have been explored under the broad umbrella term of medical culture. Two major, distinct but intertwined processes can be discerned: the missionary search for health in Livingstonia, and the African quest for health in connection with the mission and the emerging Presbyterian Church in the region. A striking contrast is apparent between the change from high rates of mortality and illness amongst missionaries during the late nineteenth-century to clear improvements in European health from the turn of the century, and the parallel history of increasing threats to African health as a result of changing disease patterns, colonial conquest and the establishment of a colonial economy in the region. Missionary medicine as such was merely a small part of these wider developments, and the official image of medical encounters produced in the mission publications was undeniably narrow, biased and propagandist.

In Livingstonia, as elsewhere, a powerful image was created of the self-sacrificing medical missionary who would patiently and effectively help the suffering, ignorant and superstitious but saveable, African patient. The missionary would cure a patient's body and contribute to the healing of his soul. Missionary writers constructed this image and the accompanying narratives out of much more complex stories of interactions that took place in the dispensaries, hospitals, the patients' homes or villages. This study has aimed to recover some of that complexity.

Missionary medicine and its practitioners

Victorian and Edwardian doctors in Livingstonia were usually ordained ministers and heads of stations as well as physicians. Similarly, nurses frequently combined their nursing with teaching positions within the mission.

Medical professionalization thus took place more slowly in Livingstonia than in many other missions, and this had important consequences for medical practice at the mission. Versatility was integral to the outward image and the self-image of medical recruits who modelled themselves after Livingstone, in particular. For these recruits heroism and adventure (pioneer as well as scientific) were important motives alongside their Christian conviction that they should participate in the mission and sacrifice themselves, symbolically and literally, for the missionary cause. Equally, medical recruits could also be driven by philanthropic motives and the promise of personal social advancement. Their multiple roles within the mission meant that they were usually only able to devote limited time to medical practice. Nevertheless, especially for missionary women, the mission experience also enabled them to expand their fields of activity in ways that were unlikely or impossible at home.

Livingstonia was for much of this period headed by Robert Laws whose practice and roles exemplified the nineteenth-century ideal of an ordained medical missionary in Africa: Laws could be a doctor, minister, teacher, builder, agriculturalist, engineer or hunter according to the needs of the mission. In spite of its many doctors, Livingstonia remained behind Blantyre and UMCA missions in the extent of its actual medical practice (as measured by the number of in-patients) well into the 1920s. The role of medicine at the Livingstonia Mission under Laws must be understood as a part of a larger individual and collective concern, “the quest for health”. Therapeutic medicine and surgery *per se* formed only one aspect of a wide-ranging programme set out by Laws and his colleagues. The central concern of the missionaries, doctors and laypeople alike was to create a healthy Christian society whilst securing their personal health and that of their families. Both curative and prophylactic ideas and practices were central to this programme.

Medicine at Livingstonia from 1875 to 1900 was above all a tool for missionary survival and expansion. Medicine was “a way-opener for the Gospel” among new peoples and polities and a weapon against African medicine and religion wielded by individual missionary doctors who were primarily the leaders and diplomats of pioneer mission parties. The medical mission in Livingstonia and the work of its practitioners changed fundamentally from around 1900. With the establishment of permanent hospitals, missionary medicine became an increasingly professionalized activity. European doctors and nurses, and African nurses and assistants were organised according to a professional, gendered and racial hierarchy. The mission hospitals established during the first two decades of the twentieth century, including the David Gordon Memorial Hospital, slowly developed into centres of Western biomedicine.

The practice of medicine was concentrated in fixed spaces of healing that were, in uTonga and uNgoni in particular, located among increasingly Christianised communities, and in the case of the DGMH, among a separate Christian educational and industrial community. Doctors were less often theologically educated reverends than fully trained medical professionals who

focused on hospital medicine. The old ideal of ordained medical missionaries acting as pioneer European agents had been largely abandoned by the 1920s. The leadership of the mission shifted from doctor-ministers to ministers, and Robert Laws' eventual retirement in 1927 was only the final confirmation of this change.

Despite developments in medical and surgical therapies and the capacity to treat increasing numbers of patients, missionary medicine at Livingstonia was never able to provide comprehensive treatment to the majority of the African population or to provide a credible alternative to local forms of therapy on a large scale. Although this was partly due to economy, staff resources and logistics, cultural and political factors were also significant. Medicine in Livingstonia was always subordinate to the main missionary programmes of evangelisation, Christian education and the creation of a Christian community. Hospital medicine and surgery were becoming increasingly expensive in the early twentieth century and while the medical staffing and infrastructure at the mission improved in the 1920s, Livingstonia always had extremely limited resources for the treatment of large numbers of patients. At the same time, there was no consensus about the evangelistic value of the mission hospital. The objective of the secular treatment of as many patients as possible was not emphasised in mission politics as a goal in itself, although this was undoubtedly the professional goal of many doctors and nurses.

While the pioneer aspect of medical evangelism never fully disappeared, its relative importance within the mission did wane. The developed mission hospital, although designed to have some purpose as a conversion tool, catered primarily for the emerging Christian community in the Northern Malawi region. The older ideas of pioneer missionary medicine gave way to an increasing emphasis on safeguarding the holistic health of the Christian community as well as the practice of medicine as an end in itself: secular philanthropy alongside a Christian expression of sympathy for the suffering. Fighting the "witch-doctor" continued to be an important part of medical missionary rhetoric and public discourse, and justified the continued existence of the medical mission. In practice, however, the missionaries had quietly recognised by the early twentieth century that many African therapies could be beneficial.

While missionary medicine concentrated on hospitals, the African population was increasingly moving away from these centres in both uNgoni and uTonga. The reasons for this population shift were varied, but both the needs of agricultural production and the demands of the colonial economy were significant. Furthermore, after the introduction of medical fees by 1908, missionary medicine was no longer a free therapeutic alternative for Africans. In colonial society the wealthiest Africans were often migrant workers who were mostly absent from the mission. However, for the hundreds of former Livingstonia pupils and apprentices, their period at the mission brought them within the sphere of influence of missionary medicine. If their experiences of missionary medicine were positive, they would arguably be more likely to

resort to Western medicine later during their careers in Southern Africa and elsewhere. Those who became relatively well-paid employees could pay for European medicine. As McCracken has shown, Livingstonia made an important contribution to the colonial economy in the region and through its education programme the mission created opportunities for social, economic and political mobility among the new Christian elite. Arguably, access to European medicine, a willingness to try new forms of treatment, and the ability to pay for treatment were largely determined by an individual's or a family's previous relationship with the mission, especially in the fields of education or employment. African Christian men in the Northern Malawi region were clearly in a better position to gain access to, and pay for Western therapies than were non-Christians or Christian women.

Missionary health and illness

During the first twenty-five years of the mission Livingstonia missionaries had to cope with alarming rates of illness and death among their own ranks armed only with very limited medical resources and at best partial knowledge about the nature of these illnesses. This contributed to the development of a particular regime of holistic hygiene in Africa, in which morality, moderation, care and control were crucial; the moral, physical and mental elements of health were inseparably interconnected, and the conservation of energy and careful living were watchwords for survival. Significantly, in these pioneer circumstances, African people were not regarded as a specific threat to missionary health. The missionaries had to encounter Africans in order to save them: any hygienic regime that aimed to segregate missionaries from Africans would have been contradictory and counterproductive.

Fevers were understood within the local environmental framework, and were believed to be caused by miasma, zymotic poisons or exposure to extreme conditions until the turn of the twentieth century. Soil, air, temperature and weather conditions were seen to be key determinants of healthiness. In the Victorian period, the tropical environment was deemed by Europeans to be inherently insalubrious. The tropics were increasingly imagined in evolutionary terms during the late nineteenth century as an area of evolutionary and racial survival.[1] Humoral pathology and ideas of holistic health informed missionary theory and practice of healthy living at Livingstonia in ways which continued to exert an important influence upon mission life well into the twentieth century.

The "chill theory" in particular influenced the pioneer missionaries' programme of preventative medicine. Protective, dry clothing and tropical helmets in particular were regarded to be essential, and the missionaries were to avoid exposure to extremes of weather. The location of the stations and

[1] Jennings 2002, p. 233, Livingstone 1999. For the changes after the turn of the century, see Anderson 1992.

housing were believed to be crucially important to the maintenance of good health. The idea of a healthy hill station, transplanted from India, informed the construction and expansion plans of the mission. Cleanliness, care and order as well as the conservation of strength and energy were essential to healthy living. Hygiene and moral hygiene in particular were also regarded to be crucial: personal habits, temperance and morality determined European survival in the tropics, and these beliefs had significant consequences for the entire colonial culture. For pioneer Europeans in Africa cleanliness and hygiene were essentially matters of self-discipline. Colonialists believed that self-control was necessary in order to control others.[2] In Livingstonia, quinine was the "sheer anchor" in prophylaxis and the treatment of fever, but a hygienic regime was a pre-condition for health. Properly measured and controlled work was beneficial to the maintenance of health while overwork and exertion could be dangerous.

Individual experience of illness could either shake or reinforce missionary morale and belief in the mission. For some such experiences strengthened their faith, whilst for others illness prompted a departure from the mission either under doctors' orders or of their own volition. Psychological and moral factors, "the spirits" of an individual, were regarded to be essential to both the maintenance of good health and recovery from illness. "Proper" religious experience and ritual, such as prayer and reading of scripture, could be an important part of missionary therapy, but uncontrolled "emotionalism" and false religious "excitement" could easily endanger mental health. This tension between the "healthy" and "unhealthy" aspects of religious life had an important lasting influence upon the attitudes and policies of the mission and the Presbyterian Church in Northern Malawi.

Despite widespread consensus over the basic principles of healthy living, in practice the quest for health among the missionaries was a complex affair. At pioneer stations, the ideals of a healthy station were seldom realised: the missionaries were frequently exposed to extreme conditions and often did not take their prophylactic quinine, at least until the 1890s. Doctors and laymen fought bitterly over whether or not certain stations were healthy and whether mission work and expansion in certain locations was possible from the point of view of European health. The health of missionaries' families, in particular, was an important factor in mission politics. Their own particular station's reputation for healthiness was an important and sensitive issue for a missionary. If a station was declared unhealthy by the home authorities and the supporting public, the likelihood was that it would be abandoned and the missionaries relocated to a new area where they would often have to begin their work from scratch: learn new vernacular languages, build new houses and possibly be subordinate to senior missionaries at the new location. Missionaries were very

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2 Johannes Fabian has argued that in the late nineteenth century, "the fever" for European explorers in Africa was more than a medical condition, but an "ecstatic counterstate to ascetic hygiene. Fever was an ideology, a myth needed to make sense of mortal dangers of exploration, a metaphor giving meaning to what would otherwise have remained brutal facts", as well as a compulsory "sacrifice". Fabian 2000, pp. 59-63; Livingstone 1999, p. 104.

sensitive about the reputation of their own stations and tended to accuse other stations of being unhealthy. Similarly, doctors and laypeople alike would stress factors other than unhealthiness of the station in their explanations and accounts of illness and death at their own station.

The pioneer missionaries' illnesses also influenced their relationships with Africans as well as each group's perception of the other. Cases of missionary illness frequently reveal the acute weaknesses, fears and uncertainties felt by the doctors. The missionaries and doctors in particular, needed to enhance the reputation of their medicine, their technology and their civilization, often by denigrating African therapies and medico-religious ideas in their publications. This attack on "witch-doctors" was one of rhetorical strategies employed by the missionaries both to boost their support at home and to keep up their own morale and a sense of medical and cultural superiority when facing terrible casualties from sickness. Thus, missionary illness contributed to the negative stereotyping of Africans, descriptions of Africa as a sick and sinful continent and other negative projections. However, the pioneer missionaries' vulnerability meant that they also frequently depended on the goodwill and support of their African associates, who nursed and fed them during sickness, transported them to safety and would not abandon them to die. This weakness could generate gratitude and respect towards Africans in line with the basic principle of charitable mission medicine: recognised sympathy in illness and offers of therapy are valued in human relations, and can overcome cultural barriers whether the sufferer is actually cured or not.

The fact that Africans sometimes encountered and perceived pioneer missionaries, including their leading physicians, as very sick individuals, in all probability counteracted the more extravagant claims about the superiority of European medicine as well as any ideas of Europeans as superior beings. However, the missionary idea that martyrdom and sacrifice in Africa was valuable to their project may have been partly realised as some of the missionaries' African associates clearly shared the pioneer missionaries' losses and grieved for them. Illness, death and healing could bring missionaries and Africans together through intensive shared experiences of pain, grief and joy, in contrast to many other areas of colonial encounters.

For the pioneer missionaries, the evangelisation of Central Africa and the establishment of the Kingdom of God were projects that required sacrifice and preparedness to suffer and even die, but not foolhardiness or the unnecessary endangerment of life. The reputation, funding and the very existence of the mission required that the mission look after its agents and their families. However, through the concept, image and symbol of martyrdom of the heroic missionary who would die to save Africans, the mission propagandists were able to portray illness and death as victories rather than defeats and successfully press the case for more, rather than less, missionary enterprise. It is noteworthy that, despite the considerable loss of health and life, the Livingstonia project was sustained and expanded and only a few outstations were abandoned due to casualties.

However, early twentieth-century Livingstonia became an increasingly healthy "colonial microenvironment" for Europeans. It is clear that the missionaries were, on the whole, much healthier after 1900 than they had been previously. The missionaries' living standards (notably station locations, housing, diet and leave conditions) improved and faster communication and transport enabled more efficient medical care and, when necessary, made it easier to return to Scotland. Improvements in medicine were readily available to the missionaries, and prophylactic and curative quinine in particular seem to have contributed to the decreased mortality rates for malaria. The decision to establish the mission headquarters and the educational centre on the high plateau at Khondowe was influenced by concern for missionary health, and the construction and organisation of the Overtoun Institution demonstrated that the maintenance of European health was foremost among the missionaries' concerns.

Peter Forster has argued that in Livingstonia, improved political security and better health for missionaries "encouraged a more patient attitude towards local cultures" in the early twentieth century.[3] In light of the evidence consulted, the influence of improved European health upon missionary attitudes towards African cultures and peoples seems more complex. It appears that the pioneer missionary doctors' condemnatory attitude towards local healers stemmed in part from the need to publicly uphold their own professional identity and pride in the face of very high rates of illness amongst missionaries. However, pioneer health conditions required the missionaries to have closer and more frequent contact with their African associates than was the case for the younger generation of missionaries.

Furthermore, changes in medical theory and new antimalarial precautions in particular created a new hygienic segregation between Europeans and Africans on the mission stations during the early 1900s. While, for the pioneer missionaries, the African environment and climate but not the African people were understood to be the main danger to European health, after the turn of the century the Africans themselves were increasingly seen as a potential source of disease. The consequent hygienic segregation both limited missionaries' contacts with Africans and their supervision of local communities, and contributed to critical African perceptions (both within and outside the Christian communities) of missionaries being part of an unfair, racially demarcated colonial society. Early twentieth-century tropical hygiene emerged as a dividing rather than integrating feature of colonial culture,[4] and conditions at the mission reflected this. In contrast therapeutic encounters between Africans and missionaries could be uniting as well as alienating, depending upon the process of negotiation, exchange and experience.

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3 Forster 2003, p. 2.

4 See Vaughan 1994b, p. 191.

Therapeutic encounters

Therapeutic encounters between missionaries and Africans rarely involved merely the healer and the sufferer. From the outset, a number of "middles" from either "side" mediated these encounters: the African members of the mission, who acted as interpreters and advisers, and the local therapy management groups. Relatives, friends and members of the political elite as well as medical and religious specialists could all be involved in the decision to send a sufferer to the missionaries. Frequently this was a last resort after local therapeutic alternatives had been exhausted, and often the missionaries were, in the end, unable to cure these cases, which was a cause of significant frustration for the mission doctors.

Nevertheless, for the pioneer missionaries, medicine was a valuable tool of diplomacy and influence, and the treatment of African elites and their associates was particularly important in this respect. It was believed that medical practice would help missionaries settle among new people and dispel suspicions about their motives and work, and thus pave the way for Christian conversion. By providing gifts of medicine and presenting surgical operations as performances, medical missionaries aimed to demonstrate that they were benevolent yet powerful people, who should be befriended and listened to. In theory, missionary medicine was supposed to prove itself superior to anything that African healers had to offer, and directly and indirectly challenge and vanquish key local religious and magical beliefs, notably the local aetiological theories of spirits and witches as causes of illness and death.

Medicine at the Livingstonia Mission only modestly fulfilled some of these exceedingly ambitious aims. The mission doctors had no difficulty in being accepted as healers of some kind by African leaders in the local pluralistic medical culture. The Ngoni society in particular had been a "melting-pot" of religious and medical ideas and practices for decades. For other groups, the nineteenth-century invasions had resulted in an unstable social and political environment in which healing was highly valued. No society completely rejected the missionary offer for therapy. At the same time, Africans held on to their therapeutic repertoire and merely incorporated the medical missionary, as an alternative and complementary specialist, into the medical culture. Missionary demonstrations of power, and surgical operations, in particular, received a mixed response from the people, and while they contributed to some recognition and respect for the missionary surgeons, the operations also created some fear and suspicion which fed the circulating stories of the Europeans as cannibals, sorcerers or generally as alien people to be wary of. For those opposing the missionaries, the images of surgeons as body-cutters could be used in the portrayal of the Europeans in a negative light just as the image of charlatan "witch-doctor" was utilised in the mission propaganda. Both African and missionary practitioners could accuse each other of "quackery": causing patient deaths or of sinister motives.

In general, the African elites accepted and tolerated mission medicine, although the chiefs themselves, who had the widest repertoire of therapy

available, were rarely treated. The majority of early African patients in Livingstonia seem to have been associates of the mission, and a large number of these were children. The numbers of patients tended to peak during the rainy season, and the most frequent complaints, notably ulcers and stomach disorders, suggest that the services of the mission dispensary were largely sought by the poor who suffered from seasonal hunger and diseases caused by malnutrition and poverty. The fact that early missionary medicine was provided free of charge was significant in this respect, although some doctors felt that free treatment undermined the value of the medicine in the eyes of the African elites. Furthermore, charitable medicine was at odds with many missionaries' Presbyterian mentality. The fears of "pauperizing" African patients and doctors being exploited prompted the missionaries to charge for their services from the turn of the century onwards. The mission aimed to create a thrifty African society of Christians who would gladly pay for their medicine, but, in reality, charging medical fees at a time of increasing colonial taxation and other acute socio-economic pressures alienated many Africans from mission medicine.

Early missionary medicine and surgery could often, at best, merely alleviate suffering rather than cure disease. However, even the most modest medical practice established important ties and networks between the missionaries and Africans from the outset. For the early associates of the mission, who were often former slaves, orphans or refugees, becoming a mission patient was an early step towards joining the mission community. The missionaries could become chiefs, heads of family and therapy managers for those without strong community ties. Many orphans who were mission pupils and personal servants eventually became the first Christians in the mission and the nucleus of the Christian community. The management of illness and therapy was an important part of this social process.

During the pioneer period, the missionaries by necessity had to recognise some aspects of African therapy management. Many patients could be treated only if their relatives or friends looked after them, and early in-patient treatment in the early hospitals was largely dependant on the therapy management group feeding, nursing and socialising with the patient. This arrangement was mutually beneficial: it decreased the costs and time required of the missionaries as well as lessening the fears and suspicions felt by the patients who were undergoing alien therapy, and allowed the therapy managers to observe the healer and if necessary interfere in the treatment. If therapy managers were in favour of missionary treatment, patients could even be taken to missionaries against their will.

Successful therapeutic exchanges linked the mission not only with the patients, but also with their families and, sometimes, entire village communities. In ideal circumstances for the missionaries, successful medical exchanges could lead to the expansion of the mission into a new village, the establishment of a school and eventual conversions to Christianity among the villagers. However, medical interaction was only one among the many

exchanges taking place, and it is difficult to assess its overall importance to the expansion of the mission and African conversion to Christianity in Northern Malawi. It is safe to say that medicine certainly played a part in that process and that without any medical contribution Livingstonia could not have expanded as successfully as it was able to. The use of medicine and surgery as gifts, performances and symbols was arguably of far more importance in this process than the medicines' medico-scientific efficacy. Early missionary medicine was, from a modern Western perspective, rather ineffective, yet it was perceived as potent and was experienced as benevolent by many, either as patients or therapy managers. However, in some cases such as successful cataract operations missionary therapy had undeniable, dramatic, and immediate positive results, and could offer genuinely beneficial and new treatment to patients.

Trained medical middles – dispensary "boys", medical assistants and nurses – emerged as a new intermediary group within missionary medicine. First trained on the job and later formally educated in the Overtoun Institution hospital, these middles, together with European nurses, ensured that the mission hospitals and dispensaries could function and treat the growing numbers of patients. By dressing ulcers, dispensing basic medicines and communicating with patients and their families, the middles made it possible for increasing numbers of Africans to approach the mission and receive therapy. They played a crucial role in persuading the patients and therapy managers to consult the missionaries and in overcoming problems and conflicts during the therapeutic process. Diagnosing a patient's illness was difficult when the doctor and the patient did not share a common language, and would have been almost impossible in some cases without the help of middles. It is remarkable that in Livingstonia, healers, patients and middles could form functional relationships despite all the cultural and linguistic obstacles. Medical practice itself offered a new medium of communication, but it was not something the missionaries could easily control. White male doctors were sometimes able to co-operate successfully with African midwives, notwithstanding barriers of language, culture and gender roles. However, many doctors felt uneasy in such situations, and often preferred the controlled environment of the consulting-room or operating theatre where they were in sovereign charge, aided by nurses and assistants, and removed from the demands of African therapy management. Control of hospital space and people was essential for modern hospital medicine, and conflict with African patterns of therapy management was unavoidable in this respect.

The organisation of hospitals as fixed spaces of healing meant that patients gradually became more isolated from their therapy management groups. Within the hospitals African mission middles performed a vital function as cultural brokers. However, the hospital in-patients could also support and encourage each other in alien circumstances and fellow patients could be important agents in the individual's response to missionary therapeutics. While for the missionaries hospitals provided the infrastructure to treat in-patients

more effectively and keep patients under controlled treatment for lengthy periods of time, the patients frequently found mission hospitals alienating and frightening, and many of the patients were not taken there by their families but rather by colonial refereeing agents.

Missionaries, the colonial administration and European settlers became important refereeing agents and supporters of mission hospitals in the early twentieth century. During the construction phase of the Overtoun Institution, Livingstonia was a major employer of migrant labour on the Khondowe plateau, and the majority of patients at the Institution were mission workers, pupils or apprentices. Here the mission did not treat sufferers of African diseases or attack the "ignorance and superstition" of African medical culture, but largely treated its own employees injured in the course of their work or who were suffering as a consequence of their environment. After the construction phase and the completion of the David Gordon Memorial Hospital, hospital attendances temporarily dropped before a new increase in the 1920s. The distance from the hospital to the centres of population, the difficulty of transport and the introduction of medical fees all made the most advanced Western medical centre in the region extremely difficult for most Africans to approach. In this case, the missionary quest for health had contributed to the establishment of a major hospital in a distant location, which permanently limited the value of the DGMH for the African population.

With the emergence of popular Christianity in Northern Malawi, Christian families and communities increasingly became important refereeing agents and publicists for the Livingstonia hospitals. The Institution-educated elite were familiar with the practices of hospital medicine, and could be valuable propagandists. However, the Christian community was not homogenous in this respect. Some were advocates for mission medicine, others were hostile, suspicious or indifferent towards it, while it appears that a majority favoured a therapeutic pluralism, where the mission hospital was merely one (often the last) therapeutic alternative.

Gender, medicine and education

The medical mission in Livingstonia was, until the early years of the twentieth century, an almost exclusively male-doctor dominated enterprise. Under the leadership of Laws, the prevailing image of the missionary as an imitator of Christ was that of a masculine leader and healer. In its early policies of recruitment and training of Christian African medical assistants, the missionaries envisaged the Christian assistant-elder as an African equivalent of a masculine missionary physician, but one who was clearly subordinate to European authority. Female missionary doctors did not fit easily into this scheme, as the case of Waterston demonstrates. The lack of female medical recruits limited the extent to which African women could be actively approached. Furthermore, the patriarchal missionary programme of education that aimed first and foremost to train women in domestic duties, constrained

the medical education and public health schemes with regard to engaging women.

However, both European and African women gained increasing prominence in the emerging hospital medicine and the day-to-day running of hospitals and dispensaries from the turn of the century onwards. Despite the paternalistic order at Livingstonia, Agnes Fraser, for one, managed to negotiate a career as both a respected doctor and a missionary wife. After the turn of the century, nurses were essential to the successful functioning of the hospitals. As MacDonald has noted, somewhat paradoxically, the missionary ideology of domesticity contained both conservative and radical elements, and the complex dynamics of race, gender and class could undermine the official missionary ideology when influencing practices in Africa as elsewhere.[5] Nursing as a professional activity was a way for both European and African Christian women to break away from the narrow domesticity imposed upon them by male-dominated institutions of society including the church, in Scotland as well as in Central Africa. The mission hospital was a hierarchical institution, with clear divisions of class, gender and race, but it also offered possibilities for co-operation and contestation of hegemony and the creation of new identities and subjectivities. African nurses, largely invisible in mission sources, were essential to the operation of hospital medicine and gradually became more recognised by the mission leadership. Like medical assistants, they could negotiate new roles, duties and images for themselves in a changing society.

For African men, a career as a medical assistant brought new possibilities for social and material improvement and mobility, but the assistants' role as male nurses and subordinates of European doctors and nurses created tensions and frustration among this group. Their status within the mission as highly educated "boys" was in the long run unbearable for many assistants. Trained African medical assistants had less autonomy than African ministers. However their status and education afforded the assistants some mobility and improved their social status. Although some became important figures in their own communities, most assistants moved increasingly beyond the mission and the Protectorate into colonial employment. Some assistants negotiated remarkably successfully between Western and African medical traditions.[6] Medical assistants often found it frustrating to work under European women within the hospital hierarchy, and by the early 1930s Livingstonia doctors were increasingly seeking African nurses to staff the hospitals. The employment of European and African women in the hospitals was partly boosted by economic considerations: they were much less costly agents than doctors and assistants.

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5 MacDonald 2000, pp. 106-107.

6 The career of Dan Jerome Ngurube, one of the last Livingtonia hospital assistants trained by Dr Todd, is illuminating in this respect. After his graduation in 1933, Ngurube worked in Government hospitals in Malawi and East Africa, and trained other assistants. After returning to Malawi from Tanzania in the 1960s, according to a close relative, Ngurube became the chairperson of African medical practitioners and taught traditional healers. Ngurube prepared his own medicines in a western way from local ingredients and advised local healers to concentrate on the dosage. Some healers opposed him, but others co-operated with him. Oral testimony, V.S.K., 11 July 2004.

Health, power and politics – missionary, African, colonial

Before the imposition of formal British rule in British Central Africa and Northern Rhodesia during the 1890s and early 1900s, the Livingstonia missionaries negotiated with sovereign African rulers. Medicine played a significant part in mission diplomacy and was one of the important ties that connected the African ruling elites, especially in uNgoni and uTonga, to the mission. Although missionaries failed to provide African rulers with war or fertility medicines, their perceived "medicine power" was an important factor within the early relationships. Furthermore, the image of Robert Laws as the leader of the mission was crucially shaped by his use of medicines and his various roles as arbiter, judge, doctor and chief of the Europeans and their dependants. Laws was perceived as a man of great and various powers, and stories and myths about him were widespread across the region.[7]

Although the temporal and judicial rule of the missionaries was kept in check in the early 1880s by the British authorities, the missionaries, and Laws in particular, continued to wield important influence and power among Africans in Bandawe and at the Overtoun Institution. The Institution emerged as a centre for training morally, physically and intellectually healthy and fit Christians, and, for Laws, authority and discipline were essential in order to achieve that end. However, Laws' concerns extended beyond the immediate Institution, its pupils, workers and infrastructure, to the surrounding villages and communities. In the absence of a colonial magistrate or resident, Laws became a semi-official colonial authority on the plateau, and medical authority was an important part of his role. With the blessing of the colonial administration, Laws could, largely, control African building, housing, living and movement over a large area, and detain those people regarded to be mentally ill, and call the Resident to punish people who had refused to take an ill person to the hospital. As the administration in the Northern Province of Nyasaland developed and communication and transport connections improved, Laws increasingly exercised his authority in close co-operation and negotiation with officials, but he continued to exert considerable powers until his retirement.

The ordering of space and movement of people were integral aspects of colonial power, and public health and hygiene motivated and justified the use of this power to a great extent. The missionaries participated fully in the colonial medical analysis of African people and their health, government public health campaigns, and the war effort between 1914 and 1918. Although there were occasional conflicts and confrontations, in general Livingstonia was a loyal and valuable ally of the British administration and its medical

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[7] As McCracken has pointed out, the connections between legends surrounding Laws and the later image and figure of Dr Hastings Banda, an autocrat physician, are fascinating but they cannot be explored in further detail here. McCracken 2000, p. 15; Hokkanen 2005b. Banda, a former Livingstonia pupil, studied medicine in the United States and Scotland in the 1920s and 1930s, had a successful private practice in London and considered a career in Livingstonia, but in the 1940s white nurses in the mission were not willing to work under a black doctor, and Banda subsequently turned to full-time politics. See Short 1974.

department. Privately, Laws could write strong critiques of the sexual behaviour of European colonialists or the treatment of Africans in military service during the World War, but publicly the mission remained silent on these politically sensitive topics. Although the missionary doctors became increasingly aware of the new disease patterns and threats to African health under the colonial economy, they never expressed serious doubts of the overall value of British rule to African well-being in Nyasaland. It is nevertheless significant that ultimately, the lasting British contribution to African health in Laws' opinion was peace, and not medical services.

The co-operation between Livingstonia and the BSAC in Northern Rhodesia was close and intense, and medical missionary services were an important part of that relationship. Livingstonia's expansion westwards was welcomed by the BSAC which needed medical care for its distant agents, and in Mwenzo, local colonialists funded the mission hospital for some years in an unprecedented way. However, there were conflicts and concerns about the mission's relationship with the BSAC and the morality of the colonial agents. Laws saw medical practice as a way of influencing the secular colonialists as well as African patients. Furthermore, for the most part, Livingstonia operated in an area where European settlers and travellers were very few in number. Economically this meant that the mission hospitals in the north received far fewer European patients and local subscriptions than the Blantyre Hospital in Southern Malawi, for example. The distance from the centres of colonial economy enabled the mission to concentrate more on its African practice, but this also handicapped its operation financially. The termination of advanced medical education for Africans at Livingstonia in the early 1930s was the result, in part, of financial constraints.

Regeneration and holistic health

Therapeutic medicine was one element of missionary health programmes, but arguably more important for the social and cultural history of the Northern Malawi region was the missionary programme of creating a healthy society in the region. Laws' project to create a physically and morally healthy, self-controlled Christian community can be called "hegemonic" with good reason. Through the project, Laws aimed to create a new lived system of meaning and values, transforming individuals and families physically, psychologically and spiritually. The objective was to form an expanding Christian elite and community that would consent to this project, in which supervision, discipline and punishment were crucial elements.

Cleanliness, as Mary Douglas pointed out, is about the correct order of things. The nineteenth-century missionary projects in Africa emphasised cleanliness with the aim, to quote the Comaroffs, of "achieving a world where all matters, beings, and bodies were in their proper place."[8] Laws' ideas must be

8 Comaroff and Comaroff 1992, p. 290.

viewed within this context: for Laws, achieving the Kingdom of God in Central Africa was about creating and arranging a healthy, clean, properly ordered society. Ideas of health, morality and evolution were central to Laws' thinking; Laws emphasised a slow holistic transformation to perfection under constant Christian supervision. It can be argued with reason that the notably slow process of gaining full church membership and the reluctance to give authority to African Christians at Livingstonia were, to a significant extent, the outcome of the philosophy and the mentality behind the programme of "regeneration". Previous studies of Laws and Livingstonia have tended to overlook this.[9]

However, the surveillance in the programme worked both ways. In an interview in 1920, when Laws increasingly emphasised European responsibility in colonial Africa, he pointed out that the missionaries were constantly and carefully scrutinised by the African communities, who would judge them by their lives and character. In the 1880s Laws told the then-young recruit Elmslie that Africans "look at us with microscopic eyes", and he continued to give this advice to new missionaries until his retirement.[10] If the missionary programme of regeneration required the constant supervision of Africans by missionaries, it also entailed African surveillance of missionaries, who had to strive to be as Christ-like as possible. This put considerable pressure on the missionaries who believed that they were constantly scrutinised, and the method of constant demonstration in some respects constrained the missionaries' lives more than those of most Africans who were sometimes able to question, challenge or simply ignore the programme.

In Livingstonia, the consumption of alcohol and sexual activity outside Christian marriage were regarded as the key threats to individual and collective health, and the mission adopted an extremely intolerant policy towards any deviation from mission rulings on these matters. Health arguments reinforced missionary condemnation of polygamy, dancing and beer-drinking. In its demand for total abstinence, Livingstonia, led by teetotallers whose attitudes towards drink were formed in industrial Victorian Scotland, adopted a harsher policy towards alcohol than any of its neighbouring missions. Total abstinence continues to characterise the Presbyterian Church in Northern Malawi even today.

Adrian Hastings has argued that, in general, the Victorian medical missionary approach appealed to Africans because it appeared to be a holistic combination of both physical and spiritual healing, in which religious and medical elements were combined. He also suspected that the missionaries themselves did not see their approach as being holistic.[11] This work has suggested that this was not the case in Livingstonia under the leadership of

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9 The results of African disappointment with the slow path to Christianity in the Livingstonia sphere have been discussed in depth by McCracken and Fields. For Laws' modern biographer McIntosh, "there seems to be no excuse for the slow ordination of African ministers". McIntosh 1993, p. 156.

10 Elmslie to Laws 1 September 1885. NLS, Acc. 9220 (1) (iii), Missionaries to Laws, 1885;Livingstone 1923, p. 371; AUL Special Collections, MS. 3289, Caseby Papers, No. 24; On African "gaze" on the early explorers, see Fabian 2000, p. 186.

11 Hastings 1994, pp. 276-277.

Laws, to whom spiritual, moral, mental and physical elements of health were inseparably and explicitly linked.

For Laws, Christianity was a regenerating force with the potential to transform individuals, families and societies totally. It was the key to saving Africa and the Africans from degeneration and death. Christianity as a comprehensive force and the idea of holistic health, where the spiritual, mental and physical were connected by energy, allowed Laws to intellectually bypass many of the prevailing social Darwinist notions of race and degeneration that heavily influenced late Victorian science and medicine. However, Laws believed that the only alternatives to progress under his guidance would be stagnation and, ultimately, regression. These issues were discussed among the elite of the Overtoun Institution in the Livingstonia Literary Society in February 1905 during a debate, *"Were the people of Central Africa progressing, standing still, or retrograding when the Gospel came"*.[12] Unfortunately, the details of this particular debate remain obscure. Nevertheless, the very fact that questions of progress versus degeneration were publicly debatable allows for the possibility that missionary ideas in this respect were openly contested by the mission-educated elite, as were questions of dancing, polygamy, and the autonomy of African churchmen.[13]

The assessment of the missionary programme of regeneration and holistic health's impact upon the emerging African Christian community and the wider culture and society in Northern Malawi requires care. The popular missionary-influenced African movements, such as the anti-beer movement in uNgoni, emerged not simply because of missionary imposition or indoctrination, but because something in the missionary assault on beer-drinking resonated with local social, political and material realities. Fields has noted how conversion to mission Christianity or the Watchtower movement in South-Central Africa enabled the people to challenge both the customary social order, and colonial rule.[14]

It is clear that many members of the Livingstonia-educated African elite were successfully incorporated into the programme of regeneration and holistic health. They attacked beer-drinking, dancing and sexual practices not only on biblical grounds, but also because these practices were regarded as being unhealthy for both the individual and society. The Livingstonia-educated elite were advocates of "healthy" and sanitary African housing and ways of living. However, the discourse of health and the rhetoric of cleanliness could also be deployed in the critique of colonialism, as the dialogues between the Mombera Native Association and the colonial authorities reveal. The influences of missionary ideology and the hegemony of health and cleanliness in Livingstonia were significant, but were far from total or exclusively missionary-controlled. The African elite, in the church as well as in the Native Associations, found ways of utilising missionary language for their own ends, contesting

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12 A syllabus for the Livingstonia Literary Society, 7th Session, 1905. NLS, Acc. 7548, D 71. Letters to the Livingstonia Sub-Committee 1905, p. 42

13 McCracken 2000, pp. 239-242 and *passim.*

14 Fields 1985.

missionary claims, and bringing forth real concerns in local society including the new "diseases of civilization", sexual morality, "bad medicines" and European exploitation of Africans.

Medicine and conversion

One important question this study has been unable to address adequately is to what extent missionary medicine succeeded in one of its main early aims: namely its contribution to African conversion to Christianity. Beyond their rhetoric of the evangelistic influence of the hospital and dispensary, the missionaries were uneasy when discussing this topic. Berkeley Robertson stated in 1908 that it was very hard to estimate "the spiritual value of the hospital."[15] It would have been morally questionable for many doctors to state that seriously ill patients were particularly susceptible to religious conversion, and that this situation should be exploited. Although in some colonial African mission hospitals in-patients were reportedly kept in hospital for an extended period solely for the purpose of conversion,[16] there is no evidence that this occurred at Livingstonia. The value of medicine to the evangelisation programme was seen mostly in indirect terms, in the creation of ties, friendship, gratitude, and goodwill, which could all pave the way for conversion.

It is difficult to see that missionary medicine would have offered such considerable therapeutic benefits to the wider African population that it would have significantly contributed to the conversion to Christianity during this period. However, the fact that political, socio-economic and ecological changes in African societies were often experienced as threats to collective and individual health may well have contributed to the large-scale Christian conversion of the 1890s and early 1900s in uNgoni and uTonga. At an individual level, there probably were people for whom the experience of healing in the mission hospital was a significant moment in the conversion process. However, probably more important was the general perception of Christianity as a new way of life that as a whole contributed to improved health and wealth. As one informant pointed out, in the early twentieth century, there was the perception among some Africans that Christians were healthier and lived longer than non-Christians.[17] Access to mission medicine was merely one part of this. It is significant that in Ngoni evangelist Daniel Nhlane's missionary-edited autobiography, Nhlane's conversion to Christianity was prompted by the illness of his child. After trying home remedies and consulting local healers in vain, Nhlane did not take the child to Dr Steele, but, after reading Luke vii. 1-10, prayed to Jesus. Nhlane promised that if He would heal his child in the same way as He had healed the child of the centurion, Nhlane and his wife would commit themselves to Christ. When the child recovered,

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15 *Annual Report for 1908*, p. 43.
16 Vaughan 1991, p. 62.
17 Oral testimony, L.H.T., 6 July 2004.

both parents agreed to become Christians. Nhlane went to the missionary doctor to tell him what had happened: all the doctor could do was to praise Nhlane's decision and encourage him to pray.[18]

Health and the emergence of the church

Missionary control over debates about sickness and health diminished during the early twentieth century as the role of local Christian elite, reverends, teacher-evangelists and elders became more significant in Livingstonia. This was partly because the missionaries had no resources for effective surveillance over the vast Livingstonia sphere of work, but also due to the fact that, by the First World War, many missionaries had also quietly recognised the value of some African therapies and concentrated their efforts on attacking such practices that they considered to be religiously unacceptable, notably forms of spirit-possession. Furthermore, the debates and resolutions in the Presbytery allowed some flexibility to local congregations, if only because many therapies were not named and specifically forbidden. The missionaries had no control over the language and terminology of illness and health, and could only try to prohibit practices if they came to their attention.

African Christians could increasingly challenge missionary hegemonic aspirations by the 1920s, both directly in the Kirk Sessions and the Presbytery, and indirectly by ignoring missionary views and settling local matters that were beyond missionaries' knowledge. They found ways to raise local concerns about health and illness, such as "bad medicines", spirit possession and leprosy, as subjects for discussion in the church and checked missionary attempts to dominate both matters of health and the disciplinary measures taken against those Christians who resorted to African forms of therapy. Within the church, missionaries and Africans negotiated with each other over their often competing, social definitions of illness. The resulting compromises allowed a great deal of flexibility to African church leaders. However, it should be noted that the Presbytery as well as the Native Associations were organisations primarily for older men, and as such they exercised paternalistic attempts to control the society and to discipline women and the young in particular. How far these policies were actually successful within local societies is beyond the scope of this enquiry.

Meeting of moral aetiologies

In theory, there were not only polarities, but also important similarities between missionary theories of health and some aspects of pre-colonial medical thought in Malawi. The idea of "moral disease" provided some common ground between missionary and African medical systems. For example, the idea that

18 Fraser 1925, pp. 89-92.

certain ailments or symptoms were the result of moral transgression could be accommodated with the missionary belief that alcoholism and sexually transmitted diseases were manifestations of moral illness. Laws' ideas of divine punishment and degeneration according to Nature's laws, for example, were not completely incompatible with African understanding of (some) illnesses being caused by the moral failures of an individual or a community. D.C. Scott argued in his *Dictionary* that in chiChewa, the concept of *mwazi*, meaning blood, temper, health, also referred to "the spiritual effect of a man on his work, the supposed communication of his spirit to what he does". Spirit (*mzimu*) and spiritual power were also crucial to the power of medicines.[19] Theoretically, *mwazi* could connect the physical and spiritual, much as "energy" did in Laws' thought.

These topics would require a separate, thorough investigation. However, it seems clear that the emergence of mission Christianity in Northern Malawi influenced local theories of illness and health in complex ways, which often went unrecognised by missionaries. As Wendroff noted, in modern Northern Malawi many Christians continue to consult local healers and diviners, but one of the causes of illness and misfortune, in addition to the familiar list of sorcerers, spirits and God, is the Devil (*Satana*). Thus missionaries brought, as part of their cultural baggage, not only Western medicines, instruments, ideas and techniques but also elements for the cultural construction of the Devil as the cause of illness, and provided grounds for Christian faith healing and prayer as a resource for health. Whether the missionaries approved of it or not, the idea of prayer to a personal God for health, wealth and increase could be, in an African context, interpreted within the pre-colonial framework of illness. Wendroff pointed out how in Northern Malawi in the late 1970s, there was "considerable overlap between instruction in concepts of Western medicine and fundamentalist Christianity", and that biblical concepts of health and aetiology appeared side by side with biomedical concepts. Supernatural elements in Christianity and in traditional religion reinforced each other[20] in ways that might have shocked Victorian missionaries such as Laws (whose medical practice nevertheless had a place for prayer). These developments, which extend beyond the scope of this study, are undoubtedly a major outcome of diverse quests for health during the colonial period.

Epilogue – pluralism and division

John McCracken concluded his study on Livingstonia with a remark that Livingstonia in Northern Malawi both extended the social scale and contributed to "divisions of new and potentially disruptive type."[21] For his part, Mpalive-Hangson Msiska, in his essay on identity formation at a mission school in

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19 Scott 1897, pp. 411, 415-416.
20 Wendroff 1985, pp. 14-32.
21 McCracken 2000, p. 344.

Livingstonia, found appropriate words to concisely summarise the complex nature of the mission:

> Livingstonia was a poison and a medicine: an authoritarian place that also engendered the development of a critical attitude towards authority; and an agent of cultural alienation that facilitated ethnic and national identity.[22]

Colonial contradictions between the tendencies both to foster African self-sufficiency and to control this process in a way that prevented or delayed it were prominent in the medical education schemes of the mission as well. As has been pointed out, the "symbolic power" of colonialists was crucial to overcoming these contradictions,[23] and it can be argued, with good reason, that medicine was an integral element in the creation and maintenance of this power. However, the power of the colonialists should not be overestimated. As Msiska notes:

> it is difficult to agree with the critique of colonial discourse…which sees colonial hegemony in terms of its own logical egoism rather than in the context of the fundamental antagonist relations between the coloniser and the colonised. I am speaking here of the primacy of experience, the empirical moment of encounter…in which the only certainty is that no one always has his way.[24]

Msiska captures the paradoxical essence of Livingstonia Mission and its institutions as sites of complex encounters where many forms of contestation and negotiation took place. Although at the level of missionary discourses, the missionaries' programme for a healthy Christian society appears easily, in theory, as a Foucauldian regime of power or a Gramscian apparatus of hegemony, it should be considered rather as something that could be challenged: an incomplete project which in practice was realised only partially if at all among the African Christians. Yet the programme was realised in part, and the emergence of a distinct medical pluralism in Christian communities in Northern Malawi is perhaps the most enduring legacy of the "long conversation" about illness and health between missionaries and Africans.

At the level of medical practice (experiences of illness and healing) it was possible to negotiate working relationships involving healers, patients, middles and therapy managers, and arrange through co-operation genuinely beneficial and new therapeutic solutions that relieved pain, cured disease or satisfied both the patient and the practitioner. However, conflict and confrontation were equally possible, and the stories of therapeutic encounters could become narratives of horror as well as tales of healing. Missionary language could express and deal with these encounters only in a very limited and biased way, but this study has aimed to demonstrate that, despite biases, gaps, uncertainties and silences, new readings, interpretations and histories can be written and missionary archives, revisited in a fruitful way. On occasion, for example, in the

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22 Msiska 1994, pp. 20 ff.

23 Fabian 1986, pp. 73-74, quoting Jewsiewicki 1979. See also Comaroff and Comaroff 1997.

24 Msiska 1994, pp. 20 ff.

later writings of Mackenzie and T.C. Young, the missionary language increasingly is influenced and replaced by the language of early twentieth-century ethnography, and this process provides valuable insights into the intellectual history of European perceptions of Africa and Africans.

In the field of illness and healing, Livingstonia offered new therapeutic resources to some while limiting alternatives for others, and although missionary medicine relieved suffering and cured individuals, it was unable to contribute to the health of most of the population who remained beyond the reach of the hospitals and the dispensaries. However, the number of people within the influence of missionary medicine steadily increased, as did the number of those who came to consider it to be a superior alternative to African therapies. There were, in all probability, very few Africans who would or could exclusively consult missionary practitioners during this period. Most Christians had to favour or at least tolerate medical pluralism and African medicines, and the church came to realise this following consultations and conflicts between missionaries and African church leaders. The church concentrated its attacks on the aspects of African medicine that were religiously problematic, notably spirit-possession and ideas of witchcraft, but even in these fields the African Christians negotiated a more tolerant policy and more flexible definitions of illness than missionary doctors would have wanted. However, the missionaries' attitude towards African healing was more ambiguous than it appeared in the missionary publications, and privately a tolerance of some African medicines increased in missionary circles during the early 1900s. Thus, the Christian medical pluralism of Northern Malawi was negotiated by both Africans and missionaries.

The study of African Christians in this work is largely based on a small sample of Livingstonia and ex-Livingstonia converts. The quests for health among Christian women, "ordinary" converts, as well as the large group of people who were not church members but in close contact with the mission and who often regarded themselves as Christians remains largely unexplored and would require further recourse to oral sources. It can be suggested, however, that the missionary and African quests for health and African interaction with missionary teaching, medicine and the church in Livingstonia had wide-ranging repercussions in the surrounding societies that were beyond missionaries' recognition and went largely unmentioned in written records.[25]

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[25] When Tomo Nyirenda, an ex-Livingstonia pupil from Karonga who become a Watchtower preacher and witch-finder, preached in Northern Rhodesia in the mid-1920s, he often emphasised the hygiene rules taught by the mission (to which he was affiliated for six years) as well as calling for witches to repent and to surrender their charms. The literate and charismatic Nyirenda preached on texts emphasising Christ's power to exorcise demons. As Ranger notes, Nyirenda was trying to establish structures for a Christian community, and appointed deacons in the villages, whose tasks included feeding and looking after strangers as well as visiting and praying for the sick. In the later part of his career, Nyirenda, who regarded himself to be above all a Christian evangelist, embarked on a witch-killing mission encouraged by a local Lala chief and was eventually hanged by the colonial authorities. Nyirenda claimed his powers to detect and kill witches came literally from "the book", apparently an issue of *The Rhodesia Methodist*

However, a caveat is in order. As pluralism implies a choice between different systems, it must be noted that not all patients had a choice about, or any previous knowledge of, the alien therapy they were subjected to. Many were sent to the mission hospital by colonial refereeing agents, while for others, the choice was made by their therapy managers. However, even for those patients who did not have any therapeutic choice, it was possible for them to make sense of their experience in various ways as active makers of their worlds rather than passive objects of medical intervention or power.

If a particular Christian medical pluralism was a major outcome of the medical encounters between missionaries and Africans, another legacy of the colonial medical encounters was the unequal access to therapy and increasing gap in health and living standards between Europeans and Africans in Northern Malawi. The contrast between African and missionary living and health conditions in the 1920s was also apparent within the Christian community. It was obvious to the African clergy as well as laymen that the missionaries were, by the 1920s and 1930s, enjoying benefits and privileges of medicine and health that were generally denied to them. Even within the inner circle of the Christian community, among those who were supposed to have the fullest benefits of missionary medicine and health provision, there was a sense of division between "European" and "African" medicine. This division was arguably most serious for those Christians who had no personal or family access to African therapies, or those who were most appreciative of Western medicine and most sceptical of African remedies.[26] John Lwanda has pointed out that by the inter-war period in Malawi, European medicine, *mankhwala achizungu*, and African medicine, *mankhwala achikuda*, had become distinct categories, but there was also a class of despised *mtela achiboyi* ("boys' " /servants' medicine). Western medicine provided to Africans was often so sub-standard that educated and wealthy Africans refused to go to hospitals.[27] The history of unequal quinine provision in the early Livingstonia is a case in point. In colonial society, access to medicines became categorised in a new way, along lines of race and class, and this was felt acutely by the African population. By its educational, social and medical policies, Livingstonia contributed to this development in ways that were in opposition to the mission's sincere attempts to provide medical aid to all Africans and to improve the overall health of the population.

Magazine. Fields 1985, pp. 164-172; Ranger 1975, pp. 45-53, 72n22. Nyirenda also attacked hemp-smoking with particular force.

[26] When missionaries shared their European foods and medicines with Africans, it was particularly appreciated. Following Mamie Martin's death in 1928, Filemon Chirwa wrote to her parents in Scotland praising her life and work in uTonga. Chirwa stressed that Mrs Martin "used to send her own European food to girls who were ill...and she was loving to the children and helped them with medicine of her own that she used with her own child...she shared much with the children of us black people" Chirwa to Mr and Mrs Telfer 26 September 1928. Sinclair 2002, p. 347.

[27] Lwanda 2002, pp. 76, 95

As Hunt has noted, no negotiation or translation is fully complete, although each have their limits and boundaries,[28] and the same holds true for histories of colonial situations. I hope that this study will make some contribution to ongoing conversations, constructions and narratives of colonial histories in Africa and the West, and if it fruitfully fosters discussion, enquiry and scholarship, it will have achieved its purpose.

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28 Hunt 1999, pp. 23-24.

YHTEENVETO

Tässä tutkimuksessa käsitellään parantamisen kulttuuria, kolonialismia ja kristittyä lähetysliikettä eteläisessä Keski-Afrikassa keskittyen Skotlannin presbyteerisen vapaakirkon Livingstonia–lähetyshankkeeseen nykyisessä Malawissa ja lähialueilla aikakautena 1875 - 1930, jolloin Livingstonia oli eteläisen Keski-Afrikan kenties merkittävin lähetyshanke. Metodologisesti tutkimus kuuluu lääketieteen kulttuuri– ja sosiaalihistoriaan ja sen tutkimuskohteina ovat terveyteen, sairauteen ja parantamiseen liittyvä ajattelu, toiminta ja kokemukset laaja-alaisesti ymmärrettynä. Tutkimuskohteena ovat lähetyssaarnaajien, afrikkalaisten sekä länsimaisten kolonialistien erilaiset pyrkimykset terveyden ylläpitoon ja sairauksien hoitamiseen. Tutkimuksen keskiössä ovat skotlantilaiset lääkärit ja sairaanhoitajat, heidän potilaansa, sekä afrikkalaiset ”välittäjät” (tulkit, avustajat, kristityt opettajat sekä afrikkalaiset sairaanhoitajat) ja paikalliset terapian hallintaryhmät (therapy management groups),[1] afrikkalaiset poliittiset eliitit ja brittiläisen siirtomaavallan edustajat. Tutkimuksessa selvitetään kuinka näiden eri toimijoiden pyrkimykset terveyteen muodostuivat, kohtasivat ja vaikuttivat toisiinsa ja koko siirtomaa-ajan kulttuuriin ja yhteiskuntaan eteläisessä Keski-Afrikassa sekä afrikkalaisten että eurooppalaisten osalta.

Lääketiede ja lähetyssaarnaajat Livingstoniassa

Kuuluisimman skotlantilaisen lääkärilähetyssaarnaajan David Livingstonen mukaan nimetty ja hänen viimeisten tutkimusmatkojensa kohdealueelle perustettu Livingstonia oli eräs aikansa merkittävimpiä ja tunnetuimpia lähetyshankkeita Afrikassa. Skotlannin presbyteerisen vapaakirkon (Free Church of Scotland) ja yksityisten varakkaiden liikemiesten rahoittama Livingstonia oli lääkärin ja lähetyssaarnaajan James Stewartin perustama ja lähes koko tutkimusjakson ajan sitä johti merkittävä lääkärilähetyssaarnaaja Robert Laws (1851 - 1934). Myöhäisviktoriaanisen ja edvardiaanisen ajan Skotlannissa vaikutti voimakas lähetysliike, jossa oli myös vahva lääketieteellinen elementti ja skotlantilaisia lääkäreitä ja sairaanhoitajia lähti runsaasti lähetystyöhön Euroopan ulkopuolelle. Livingstonian skotlantilaiseen henkilökuntaan kuului poikkeuksellisen suuri joukko koulutettuja lääkäreitä ja vuosisadan vaihteesta alkaen myös sairaanhoitajia. Näiden lääkärilähettien roolit ja tehtävät olivat kuitenkin hyvin moninaiset lääkärien toimiessa usein myös pappeina sekä lähetysjohtajina ja sairaanhoitajien toimiessa opettajina.

Livingstoniassa lääketieteen ja lääkintätoimen (missionary medicine) harjoittaminen oli alisteinen lähetyssaarnaajien päätehtävälle, afrikkalaisen kristityn yhteiskunnan ja kirkon perustamiselle. Huolimatta lukumääräisesti suures-

[1] Eteläisen Afrikan parantamiskulttuureissa terapian hallintaryhmän muodostavat tavallisesti sairaan lähisukulaiset ja ystävät. Ryhmä päättää parantajien puoleen kääntymisestä ja hoitotoimenpiteistä, ja osallistuu aktiivisesti hoitoon koko sairauden ajan.

ta lääkärikunnastaan Livingstonian edellytykset hoitaa afrikkalaisia potilaita olivat suhteellisen vaatimattomat jopa verrattaessa pienempien lähetyshankkeiden toimintaan lähialueilla. Terveyden ylläpito ja sairauksien parantaminen olivat keskeisellä sijalla Livingstoniassa, mutta varsinainen sairaan- ja terveydenhoitotyö oli vain osa Robert Lawsin johtamien lähetyssaarnaajien kokonaisvaltaista ohjelmaa terveen kristityn yhteisön luomiseksi.

Ennen 1900-luvun vaihdetta Livingstonian pioneerilähetyssaarnaajat kärsivät paljon erityisesti malariasta ja ajanjaksolla 1875 - 1900 lähes joka neljäs Livingstonian lähetyssaarnaajista menehtyi ja monet muut joutuivat palaamaan Skotlantiin terveydellisistä syistä. Ennen kuin moskiittojen rooli malarian levittäjinä selvisi 1890-luvulla ja kiniinin käyttö malarian ehkäisyssä ja hoidossa vakiintui, eurooppalaisten kolonialistien parissa vallitsi hyvin kirjavia käsityksiä ”afrikkalaisten kuumeiden” torjunnasta ja hoidosta. Kuumeet ymmärrettiin paikallisten maantieteellisten ja ilmasto-olosuhteiden viitekehyksessä ja niiden uskottiin johtuvan maasta, vedestä tai ilmasta leviävästä miasmasta, zymoottisista myrkyistä, altistumisesta äärimmäisille sääolosuhteille tai jostakin näiden eri tekijöiden yhdistelmästä.

Lawsin johtamassa Livingstoniassa omaksuttiin erityinen kokonaisvaltaisen hygienian oppi, jossa korostettiin varovaisen kristillisen elämän, kohtuullisuuden, kovan mutta oikein mitoitetun työnteon, täysraittiuden ja huolellisesti suunnitellun asumisen merkitystä. Moraalinen, fyysinen ja hengellinen terveys olivat toisiinsa erottamattomasti kietoutuneita Lawsin ja hänen kollegoidensa ajattelussa ja toiminnassa. Erityisesti energian ja ”hermovoiman” varjeleminen oli keskeistä kokonaisvaltaiselle terveelle elämälle holistisen hygienian vaatimusten mukaisesti. Tämä kokonaisvaltainen terveysajattelu vaikutti merkittävästi Livingstonian yhteisöön vielä pitkälle 1900-luvulle. Merkittävää oli myös se, että ennen vuosisadan vaihdetta lähetyssaarnaajien ajattelussa Afrikka ymmärrettiin terveydelle vaaralliseksi ympäristöksi, mutta afrikkalaista väestöä ei erityisesti pidetty terveysuhkana.

Hygienia ja terveysolot

Lähetyssaarnaajien korkea kuolleisuus ja sairastavuus 1800-luvun lopulla vaikutti myös heidän suhtautumiseensa afrikkalaisiin ja vuorovaikutussuhteisiin skotlantilaisten ja malawilaisten välillä. Lähetyslääkärit olivat usein sangen voimattomia trooppisten sairauksien edessä, mikä lisäsi lääkärien tarvetta korostaa länsimaisen lääketieteen, lääkkeiden ja kirurgian ylivoimaisuutta afrikkalaisiin parannuskeinoihin verrattuna lähetyspropagandassa. Lähetysjulkaisuissa afrikkalaiset parantajat esitettiin karikatyyrimäisinä ”noitatohtoreina” jotka oli tuomittu häviämään taistelu lääketiedettä ja kristinuskoa vastaan. Lähetyssaarnaajien sairauskokemukset vaikuttivat täten Afrikan ja afrikkalaisten esittämiseen negatiivisten stereotypioiden kautta. Toisaalta, pioneerilähettien haavoittuvaisuus merkitsi sitä, että he olivat sairastaessaan usein täysin riippuvaisia afrikkalaisista kumppaneistaan, työntekijöistään tai naapureistaan jotka ruokkivat ja hoitivat heitä, kantoivat heidät hoidettaviksi eivätkä hylänneet hei-

tä kuolemaan. Tämä lähetyssaarnaajien heikkous saattoi synnyttää heissä kiitollisuutta ja kunnioitusta afrikkalaisia kohtaan aivan kuten lähetyssaarnaajien lääkintätyön oli tarkoitus luoda kiitollisuutta ja rakentaa ystävällisiä suhteita skottien ja afrikkalaisen väestön välille. Afrikkalaiset puolestaan näkivät lähetyssaarnaajat usein hyvin sairaina ja fyysisesti heikkoina ihmisinä, ja nämä havainnot asettivat kyseenalaisiksi lähetyssaarnaajien liioitellut väitteet länsimaisen lääketieteen ylivertaisuudesta afrikkalaiseen lääkintäkulttuuriin verrattuna samoin kuin ideat eurooppalaisista ylivoimaisina, jopa yliluonnollisina olentoina.

Lähetyssaarnaajien terveysolot Livingstoniassa paranivat selvästi vuosisadan vaihteesta alkaen, ja 1900-luvun alussa lähettien kuolemat kävivät harvinaisiksi. Lähetyssaarnaajien yleinen elintaso, asuinolosuhteet, ruokavalio ja mahdollisuudet lomiin paranivat, viestintä- ja kulkuyhteydet kehittyivät ja malarian sekä muiden trooppisten sairauksien hoitomenetelmät edistyivät. Livingstonian pääaseman rakentaminen 1890-luvulla Khondowen ylängölle oli osaltaan seurausta lähetyssaarnaajien pyrkimystä terveempiin olosuhteisiin mahdollisimman korkeaan ja viileään ympäristöön. Khondoween perustettiin myös Livingstonian tärkein oppilaitos, Overtoun–Instituutti afrikkalaisille opettajille, saarnaajille, pastoreille ja käsityöläisille sekä Livingstonian keskussairaala, David Gordon Memorial Hospital, joka avattiin vuonna 1911.

Muutokset länsimaisen trooppisen lääketieteen paradigmassa moskiittojen ja malarian yhteyden selvittämisen jälkeen heijastuivat nopeasti myös terveysajatteluun Livingstoniassa. Uusissa opeissa malarian ehkäisemiseksi afrikkalainen väestö ymmärrettiin uudella tavalla potentiaalisiksi taudinkantajiksi, joista eurooppalaiset asuinympäristöt tuli eristää mahdollisuuksien mukaan. Hygienian vaatimuksesta erottelu afrikkalaisten ja eurooppalaisten välillä korostui, ja tämä vaikutti myös lähetysasemien rakenteeseen ja toimintaan. Seurauksena oli levenevä kuilu lähetyssaarnaajien ja afrikkalaisten välillä, joka sekä rajoitti lähettien kontakteja afrikkalaisten kanssa että lisäsi afrikkalaisten kritiikkiä eurooppalaisia kohtaan. 1920- ja 1930-luvuilla afrikkalaiset näkivät myös lähetyssaarnaajat usein osana rakenteellisesti ja rodullisesti epätasa-arvoista siirtomaayhteiskuntaa. 1900-luvun alun länsimaiset hygienian teoriat ja käytännöt muodostivat ja ylläpitivät erotteluja eurooppalaisten ja afrikkalaisten välillä. Sen sijaan terapeuttiset, sairaanhoidolliset, kohtaamiset lähetyssaarnaajien ja paikallisen väestön kesken saattoivat olla niin yhdistäviä kuin erottaviakin, riippuen siitä, kuinka erilaiset neuvottelu- ja vuorovaikutusprosessit kehittyivät ja kuinka hoitoprosessit koettiin hoitajien, potilaiden ja erilaisten välittäjien tahoilta.

Terapeuttiset kohtaamiset

Kanssakäyminen lähetyssaarnaajien ja afrikkalaisten potilaiden välillä oli harvoin kahdenkeskistä. Livingstonian perustamisesta saakka joukko afrikkalaisia välittäjiä oli mukana näissä kohtaamisissa kummaltakin puolelta. Livingstonian puolelta tärkeässä roolissa olivat afrikkalaiset työntekijät (1870- ja 1880-luvuilla

erityisesti Kapmaasta tulleet Xhosa-lähetit) jotka toimivat tulkkeina ja neuvonantajina. Vuosisadan vaihteesta alkaen neuvotteluissa terapiasta ratkaisevaan asemaan nousivat Livingstonian afrikkalaiset mies- ja naissairaanhoitajat sekä ensimmäisen polven kristitty eliitti. Potilasta ja paikallisyhteisöä puolestaan edustivat erilaiset terapian hallintaryhmät, joilla oli omat hierarkiansa ja päätöksentekotapansa. Potilaan sukulaiset, ystävät ja paikalliset päälliköt, uskonnolliset johtajat ja parantajat saattoivat kaikki vaikuttaa päätökseen lähettää potilas lähetyssaarnaajien hoitoon, ja terapian hallintaryhmä osallistui usein aktiivisesti myös itse hoitoon huoltaen potilasta, kommentoiden hoitotoimenpiteitä ja päättäen hoidon jatkamisesta. Monesti lähetyssaarnaajien apuun turvauduttiin vasta kun kaikki muut hoitovaihtoehdot olivat osoittautuneet tehottomiksi, ja yleensä tällaisissa tapauksissa myöskään lähetyslääkärit eivät pystyneet parantamaan potilaita, mikä herätti lääkäreissä turhautumista.

Lähetyssaarnaajien praktiikan ja hoitomahdollisuuksien rajoituksista huolimatta lääkintätyötä pidettiin arvokkaana työkaluna pioneerilähettien diplomatialle ja pyrkimyksille vaikutusvallan hankkimiseen afrikkalaisten keskuudessa. Lähetyssaarnaajat uskoivat että lääkintätyön avulla heidät hyväksyttäisiin paikallisten yhteisöjen keskuuteen ja että se hälventäisi valkoisiin kohdistuvia ennakkoluuloja, loisi ystävyyssuhteita ja kiitollisuuteen perustuvia siteitä ja täten loisi pohjaa lähetyssaarnaajien päätavoitteelle, afrikkalaisten käännyttämiselle kristinuskoon. Lääkkeet lahjoina ja kirurgiset toimenpiteet näytöksinä oli tarkoitettu osoittamaan että lähetyslääkärit olivat hyvää tarkoittavia mutta voimakkaita ihmisiä, joihin kannatti ystävystyä ja joiden mielipiteitä kannatti kuunnella. Teoriassa lähetyslääketieteen piti osoittautua täysin ylivoimaiseksi paikalliseen parannuskulttuuriin verrattuna ja joko suoraan tai epäsuorasti kyseenalaistaa, haastaa ja lopulta syrjäyttää tärkeät paikalliset uskonnollis-maagiset käsitykset sairauksien syistä, erityisesti etiologiset teoriat hengistä ja noidista sairauksien ja kuoleman aiheuttajina.

Livingstoniassa harjoitettu lääketiede kykeni täyttämään vain vaatimattomasti sille asetetut kunnianhimoiset tavoitteet. Afrikkalaiset kyllä hyväksyivät lähetyssaarnaajat jonkinlaisina parantajina osaksi paikallista moniarvoista parannuskulttuuria, jossa oli hyvin monia tapoja ja käsityksiä sairauksista ja niiden hoitamisesta ja jossa eri kansojen kesken oli käyty rikasta kulttuurivaihtoa jo pitkään ennen eurooppalaisten saapumista. 1800-luvun lopun Malawi oli poliittisesti, taloudellisesti ja yhteiskunnallisesti käymistilassa afrikkalaisten ja kolonialististen valloitusretkien ja muuttoliikkeiden seurauksena, ja epävakaissa oloissa pyrkimys kollektiivisen ja henkilökohtaisen terveyden turvaamiseen korostui. Lähetyssaarnaajien lääkintätarjouksia ei missään torjuttu täysin, mutta afrikkalaiset eivät myöskään luopuneet omista parannuskeinoistaan ja hyväksyivät lähetyssaarnaajat ainoastaan täydentävinä parantajina parantamisen kulttuuriin. Lähetyslääkäreiden voimannäytöt, erityisesti kloroforminukutuksessa suoritetut leikkaukset, saivat ristiriitaisen vastaanoton. Kirurgia herätti kunnioitusta ja kiinnostusta, mutta myös pelkoa ja epäluuloja, ja lähetyssaarnaajia saatettiin pitää yhtä lailla taikuuden harjoittajina tai jopa kannibalistisina noitina kuin hyvää tarkoittavina parantajina. Afrikkalaiset, jotka vastustivat

lähetyssaarnaajien toimia, saattoivat esittää kirurgit epäilyttävinä ruumiinsilpojina, aivan kuten lähetyssaarnaajat esittivät afrikkalaiset parantajat ”huijarinoitatohtorin” negatiivisen stereotypian kautta. Kilpailussa potilaista sekä afrikkalaiset että skotlantilaiset parantajat saattoivat syyttää kilpailijoitaan huijaamisesta, potilaiden kuoleman aiheuttamisesta tai kyseenalaisista motiiveista.

Yleisesti ottaen afrikkalainen eliitti hyväksyi lähetyssaarnaajien lääkintätoimen silloinkin kuin lähettien ei sallittu avata kouluja. Tässä suhteessa lähetyslääkäreiden diplomatiaa voidaan pitää sangen onnistuneena, ja muutamissa tapauksissa johtavien päälliköiden, heidän puolisoidensa tai lapsiensa onnistunut hoito oli tärkeä osa hyvien suhteiden muodostamista ja ylläpitoa. Itse päälliköitä hoidettiin kuitenkin harvoin. Suurin osa Livingstonian varhaisista potilaista oli lähetysasemalla asuvia, sen palveluksessa olevia tai välittömän lähiympäristön asukkaita. Lapsipotilaiden osuus oli suuri, potilasmäärät olivat suurimmillaan sadekaudella (etenkin joulu-helmikuussa) ja yleisimmät terveysongelmat, erilaiset märkähaavat ja vatsavaivat, viittaavat siihen, että lähetyssaarnaajien apua etsivät ennen kaikkea yhteisön köyhimmät jäsenet jotka kärsivät eniten kausittaisista nälänhädistä ja aliravitsemuksesta seuraavista sairauksista. Tässä suhteessa oli merkittävää, että ennen vuotta 1908 Livingstoniassa hoito oli afrikkalaisille pääsääntöisesti ilmaista, vaikka eräät lääkärit uskoivat, että ilmainen hoito alensi heidän työnsä arvoa afrikkalaisten silmissä ja johti lääkäreiden hyväksikäyttöön. Ilmainen hoito ei myöskään sopinut presbyteeristen lähettien suunnitelmaan luoda ahkera, rahaa ansaitseva ja palveluksista maksava afrikkalainen kristillinen yhteisö, ja tästä syystä sekä kasvavista taloudellisista paineista johtuen Livingstoniassa alettiin periä hoitomaksuja 1900-luvun alussa. Tilanteessa, jossa afrikkalaiset olivat kasvavien taloudellisten paineiden alla ja siirtomaahallinnon pakkoverotuksen alaisina, eikä lähetyssaarnaajilla ollut tarjota merkittävästi parempaa hoitoa kuin ennen, tämä johti monien afrikkalaisten vieraantumiseen lähetyssairaaloiden ja –apteekkien palveluksista.

Lähetyssaarnaajien lääkintätyö kykeni usein parhaimmillaankin vain lievittämään kärsimystä eikä parantamaan sairauksia laajassa mittakaavassa. Tästä huolimatta vaatimattominkin lääkintätoimi saattoi muodostaa tärkeitä siteitä ja verkostoja lähetyssaarnaajien ja afrikkalaisten välille Livingstonian perustamisesta alkaen. Monet Livingstonian varhaisista afrikkalaisista jäsenistä olivat orpoja, karanneita orjia tai pakolaisia, joilla ei ollut toimivia sosiaalisia turvaverkkoja eikä terapian hallintaryhmiä tukenaan. Heille lähetysasemalta saatu hoito oli tärkeä osa liittymistä osaksi Livingstonian varhaista afrikkalaista yhteisöä.

Olosuhteiden pakosta lähetyssaarnaajien oli etenkin ennen pysyvien sairaaloiden perustamista hyväksyttävä ja tultava toimeen afrikkalaisen terapian hallinnan kulttuurin kanssa. Monia potilaita voitiin hoitaa vain mikäli heidän sukulaisensa toivat heidät lähetysasemalle ja huolehtivat heidän ylläpidostaan. Mikäli yhteistyö sukulaisten kanssa sujui, se oli kummankin osapuolen kannalta hyödyllistä, ja mikäli terapian hallintaryhmä kannatti lähetyssaarnaajien hoitoa, potilaat voitiin tuoda hoitoon vasten tahtoaan. Onnistuneet kanssakäymiset

sairaanhoidossa loivat tärkeitä siteitä lähetysasemien ja yksilöiden, perheiden ja kokonaisten kyläyhteisöjen välille. Lähetyssaarnaajien kannalta ideaalisessa tilanteessa onnistunut hoitosuhde johti esimerkiksi lähetyskoulun avaamiseen parantuneen potilaan kotikylässä ja aikanaan kristinuskon omaksumiseen siellä. Sairaanhoito oli kuitenkin vain yksi ala, jonka puitteissa Livingstonia muodosti yhteyksiä ympäristönsä yhteisöihin, ja sen kokonaismerkitystä lähetyshankkeen laajenemiselle ja afrikkalaisten kääntymiselle kristinuskoon alueella yleisesti on hyvin vaikea arvioida. Voidaan kuitenkin sanoa, että sairaan- ja terveydenhoidolla oli oma osansa näissä laajoissa ja monimutkaisissa prosesseissa ja että ilman lääkintätyötä Livingstonia ei olisi luultavasti laajentunut siinä määrin kuin se teki ennen ensimmäistä maailmansotaa. Lääkintätyön ja kirurgian merkitys lahjoina, symboleina ja näytöksinä oli tässä suhteessa tärkeämpää kuin lähetyssaarnaajien todellinen kyky parantaa ihmisiä. Nykyisen lääketieteen historian näkökulmasta Livingstonian lähetyssaarnaajien lääkintätyö oli sangen tehotonta: silti se koettiin hyödyllisenä ja mielekkäänä monien afrikkalaisten potilaiden tai terapian hallinnasta päättävien taholta.

Afrikkalaiset sairaanhoitajat mahdollistivat 1900-luvun alussa perustettujen pysyvien lähetyssairaaloiden toiminnan. Heillä oli usein ratkaisevan tärkeä rooli potilaiden ja heidän omaistensa taivuttelemisessa suostumaan sairaalahoitoon. Sairaaloiden organisoituminen vähitellen pysyviksi, länsimaisen mallin mukaisiksi hierarkkisiksi instituutioiksi merkitsi sitä, että vuodepotilaat joutuivat erotetuksi omaistensa tukiryhmästä, ja afrikkalaiset sairaanhoitajat mahdollistivat tämän toimimalla kulttuurisina välittäjinä.

Terveys ja vallankäyttö

Ennen brittiläistä siirtomaavalloitusta 1890-luvun alussa, skotlantilaiset lähetyssaarnaajat toimivat itsenäisten afrikkalaisten hallitsijoiden alueilla, ja heidän koko toimintansa perustui afrikkalaisten vallanpitäjien suvaitsevaisuuteen eteläisessä Keski-Afrikassa. Lääkintätyöllä oli tärkeä osa lähetysdiplomatiassa ja se oli yksi tärkeistä siteistä, jotka yhdistivät afrikkalaiset eliitit erityisesti Ngonimaassa (uNgoni) ja Tongamaassa (uTonga) Livingstoniaan. Afrikkalaiset johtajat pyrkivät hankkimaan pioneerilähetteiltä erityisesti hedelmällisyyttä ja sodankäyntiä edistäviä lääkkeitä. Vaikka skottilääkärit eivät voineetkaan tarjota tällaisia resursseja, heillä ja erityisesti Robert Lawsilla uskottiin olevan laaja-alaisia lääkkeisiin perustuvia maagisia voimia. Laws ymmärrettiin paikallisessa kulttuurissa voimakkaaksi päälliköksi, jonka toiminnassa lääkkeillä oli keskeinen rooli, oli kyseessä parantaminen, tuomitseminen tai poliittinen johtajuus. Osin tarkoituksella, mutta tiedostamatta kaikkia toimintaansa liitettyjä kulttuurisia merkityksiä, Laws pyrki esiintymään lääkärinä, tuomarina ja vahvana johtajana turvatakseen Livingstonian toiminnan epävarmoissa pioneeriolosuhteissa.

Siirtomaavallan vakiintuminen asetti rajoituksia lähetyssaarnaajien suoralle ja epäsuoralle vallankäytölle, mutta Lawsin johtamilla lähetyssaarnaajilla oli huomattava valta afrikkalaisiin oppilaisiinsa, työntekijöihinsä ja myös paikalli-

siin kyläyhteisöihin Khondowen ylätasangolla, jonne Livingstonian keskus perustettiin 1890-luvun puolivälissä. Overtoun -Instituutin tarkoitus oli kouluttaa ja kasvattaa moraalisesti, fyysisesti ja hengellisesti terveitä afrikkalaisia kristittyjä, ja Lawsille auktoriteettiasema ja ankara kurinpito olivat välttämättömiä tavoitteeseen pääsemiseksi. Lawsin vallankäytössä terveyden ylläpidolla oli keskeinen asema, ja virallisen siirtomaavallan edustajan puuttuessa hänen valtansa ulottui myös Insitituutin lähikyliin.

Tilan ja ihmisten hallinta oli keskeisellä sijalla kolonialistisessa vallankäytössä ja hygienia sekä terveydenhoito oikeuttivat ja motivoivat tätä vallankäyttöä merkittävällä tavalla. Lähetyssaarnaajat osallistuivat aktiivisesti siirtomaavallan pyrkimyksiin luokitella ja analysoida afrikkalaista väestöä ja heidän terveydentilaansa samoin kuin virallisiin terveyskampanjoihin. He tukivat myös täysin brittien sotatoimia ensimmäisen maailmansodan aikana. Huolimatta satunnaisista erimielisyyksistä ja konflikteista, Livingstonia oli brittiläisen siirtomaavallan uskollinen liittolainen ja kannattaja. Laws kritisoi tosin voimakkaasti eurooppalaisten kolonialistien sukupuolikäyttäytymistä sekä afrikkalaisten kohtelua sotapalveluksessa, mutta vain yksityisesti. Vaikka lähetyslääkärit tiedostivat 1900-luvun kuluessa yhä selvemmin siirtomaatalouden haitalliset vaikutukset afrikkalaisiin terveysoloihin, he eivät koskaan kyseenalaistaneet brittiläisen siirtomaavallan oikeutusta tai arvoa. On kuitenkin huomattavaa, että pitkän uransa lopulla Robert Laws näki siirtomaavallan tärkeimpänä panoksena afrikkalaisten terveysoloihin rauhallisten olojen takaamisen varsinaisen sairaan- ja terveydenhoidon sijasta.

Terveyskäsitykset ja kirkko

Lawsin johdolla Livingstoniassa pyrittiin luomaan fyysisesti ja moraalisesti terve kristitty yhteiskunta, joka pitäisi huolen omasta terveydestään. Lawsin holistisen hygienian ohjelmaa voidaan pitää hegemonisena hankkeena, jossa pyrittiin luomaan uusi elämäntapa ja arvomaailma, kouluttamalla ensin pieni kristitty eliittiryhmä, joka hyväksyisi lähetyssaarnaajien ohjelman ja sitten toteuttaisi sitä edelleen laajenevassa kristityssä yhteisössä.

Livingstoniassa koulutettu afrikkalainen kristitty eliitti omaksui kiistatta joitakin piirteitä lähetyssaarnaajien ohjelmasta. Monet heistä hyökkäsivät esimerkiksi paikallista olutkulttuuria, tanssimista ja moniavioisuutta vastaan paitsi uskonnollisin, myös terveydellisin perustein. Afrikkalaiset kristityt kuitenkin myös kyseenalaistivat lähetyssaarnaajien pyrkimykset määrätä siitä, mikä oli tervettä ja mikä sairasta, ja omaksuivat lähetyssaarnaajien terveyden merkitystä korostavan kielen valikoivasti omiin tarkoituksiinsa. Terveyden ja puhtauden vaatimusten nojalla kristityt saattoivat esimerkiksi kritisoida siirtomaavallan epäkohtia ja nostaa esille paikallisyhteisön huolet noituudesta ja myrkyttämisestä.

1900-luvun alusta saakka lähetyssaarnaajien rooli Livingstoniassa väheni samalla kun afrikkalaisten kristittyjen rooli korostui. Jo ennen ensimmäisten afrikkalaisten pastorien vihkimistä 1914, afrikkalaiset saarnaajat ja seurakunnan

vanhimmat (elders) olivat enemmistönä Livingstonian Presbyteriossa. Livingstonian toiminta-alueen laajennuttua (suurimmillaan Livingstonia kattoi Englannin ja Walesin kokoisen maa-alueen) pienellä lähetyssaarnaajajoukolla ei ollut mitään mahdollisuuksia valvoa tehokkaasti kaikkia seurakuntia ja kyliä, ja afrikkalaiset kirkonmiehet saivat yhä autonomisemman aseman. Ensimmäinen maailmansota, joka häiritsi vakavasti Livingstonian toimintaa, vauhditti tätä kehitystä. Kaukana lähetyssairaaloista ja –apteekeista toimiessaan heidän oli huolehdittava seurakuntiensa fyysisestä terveydestä hengellisen hyvinvoinnin lisäksi, ja heidän oli itsenäisesti päätettävä, mitkä paikalliset parannuskeinot olivat hyväksyttäviä. Afrikkalaiset kristityt johtajat valitsivat selvästi suvaitsevaisemman ja moniarvoisemman suhtautumisen afrikkalaiseen parantamiseen kuin lähetyssaarnaajat, ja avoimet konfliktit paikallisten parantajien kanssa olivat poikkeuksellisia.

Ensimmäiseen maailmansotaan mennessä myös monien lähetyssaarnaajien käsitykset afrikkalaisesta parantamisesta olivat muuttuneet ja vaikka virallisesti he yhä esittivät afrikkalaiset parantajat negatiivisesti ”noitatohtoreina”, useimmat lähetyslääkärit hiljaisesti myönsivät että jotkut afrikkalaiset hoitokeinot olivat toimivia. Lähetyssaarnaajat keskittivätkin hyökkäyksensä niitä afrikkalaisen parannuskulttuurin piirteitä vastaan joita he pitivät uskonnollisesti mahdottomina hyväksyä, erityisesti noituus- ja taikuuskäsityksiin ja henkipossession (Pohjois-Malawissa 1800-luvun lopulla yleistynyt monitahoinen *vimbuza-virombo-vyanusi*-ilmiö, jossa potilas ymmärretään olevan vieraan hengen vallassa, ja jonka hoidossa musiikilla ja tanssilla on keskeinen rooli) hoitoon.

Afrikkalaiset kristityt saattoivat 1920-luvulle tultaessa haastaa lähetyssaarnaajien terveys- ja sairauskäsitykset avoimesti seurakunnissa ja presbyteriossa. He saattoivat myös yksinkertaisesti jättää lähetyssaarnaajat huomiotta ratkoessaan paikallisyhteisön asioita näiden tietämättä. Kirkossa käydyissä keskusteluissa afrikkalaiset ja lähetyssaarnaajat neuvottelivat ja kamppailivat sallitusta ja kielletystä terveydenhoidossa ja seurauksena oli kompromisseja, jotka antoivat afrikkalaisille kristityille johtajille huomattavasti toiminnan ja tulkinnan vapautta. Lähetyssaarnaajat eivät voineet koskaan hallita täysin keskustelua sairaudesta ja parantamisesta ja saattoivat pyrkiä kieltämään vain poikkeuksellisen näkyviä tapoja.

Livingstonian vaikutus parantamisen kulttuuriin Pohjois-Malawissa oli monitahoinen, mutta siirtomaa-ajan kulttuuristen parantamiskohtaamisten keskeinen perintö on tiivistettävissä toisaalta moniarvoisuuteen, toisaalta eriarvoistumiseen. Lähetyssaarnaajien tavoitteista huolimatta heidän välittämänsä länsimainen lääketiede ja terveydenhoito sekä kokonaisvaltaisen kristillisen terveen elämän opit ja tavat omaksuttiin vain valikoivasti, osaksi uutta afrikkalaista kristillistä moniarvoista parannuskulttuuria. Siirtomaa-aikana ero eurooppalaisten ja afrikkalaisten terveysoloissa ja yleisessä elintasossa kasvoi huomattavasti 1900-luvun alkuvuosina. Siinä missä eurooppalaisten olot paranivat, afrikkalaisten terveysoloihin lähetyssaarnaajien lääkintätyöllä ei ollut merkittävää kokonaisvaikutusta. 1920-luvulle tultaessa myös afrikkalainen kristitty eliitti, jolla oli parhaat mahdollisuudet hyödyntää lähetyssairaaloita ja –

apteekkeja, oli kasvavassa määrin tietoinen taloudellisesta ja terveydellisestä eriarvoisuudesta eurooppalaisten ja afrikkalaisten välillä.

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APPENDICES

1 European doctors and nurses in the Livingstonia Mission, 1875-1927[1]

Name	In service	Notes
1. Rev. Robert Laws	1875-1927	Head of mission, 1877-1927.
2. Rev. William Black	1876-1877	Died 1877.
3. Rev. James Stewart	1876-1877	Founder of the mission. Principal, Lovedale Institute, South Africa.
4. Jane E. Waterston	1879-1880	Resigned. Later private practice in South Africa.
5. Rev. Robert Hannington	1881-1882	Invalided home. Later missionary in Constantinople.
6. William Scott	1883-1885	Resigned/invalided.
7. Walter Elmslie	1884-1924	Ordained 1899.
8. Rev. David Kerr-Cross	1885-1897	Resigned. Joined the Protectorate Administration.
9. Rev. George Henry	1887-1893	Died 1893.
10. Rev. George Steele	1890-1895	Died 1895.
11. Rev. David Fotheringham	1890-1893	Resigned.
12. George Prentice	1894-1925	Ordained 1899. Resigned. “Went back to Africa.”
13. Rev. J.C. Ramsay	1896-1898	Invalided, “blackwater fever”.
14. A.W. Roby-Fletcher	1897-1898	Died 1898.
15. Margaret McCallum	1897-1900	Married Charles Stuart in 1900. Remained in Livingstonia.

[1] Livingstonia Staff-Book, NLS, Acc. 7548 D 73; Staff Record Book, NLS, Acc. 7548 D 72; *Annual Reports 1900-1914; Proceedings and Debates of the Free Church of Scotland, Reports on Foreign Missions 1875-1929;* Aberdeen University, *Roll of Graduates, 1860-1900.* Aberdeen 1906; Lamb 1956; McIntosh 1993. WFM = missionary employed by the Women’s Foreign Missions Committee of the United Free Church of Scotland. The end dates of some missionaries’ periods of service are unknown.

16. Maria Jackson	1897-1900	Married Malcolm Moffat. Remained in Livingstonia.
17. Robert Scott	1898-1900	Resigned.
18. Frank Innes	1899-1921	Ordained 1903. Resigned.
19. James Chisholm	1900-1936	Ordained 1905. Died in Mwenzo, N. Rhodesia.
20. Ernest A. Boxer	1900-1905	Resigned.
21. Agnes Fraser	1901-1925	Not appointed, married to Rev. Donald Fraser.
22. Mary J. Fleming	1900-1903	Resigned on health grounds.
23. Miss J. Martin (Honorary nurse)	1900-1909	Retired.
24. Winifred Knight	1901-1905	Married Dr Boxer 1903, died 1905.
25. Mary Henderson	1904-	
26. Alexander Brown	1905-1912	Resigned, transferred to India.
27. Mary Ballantyne	1905-	
28. Berkeley Robertson	1906-1910	Resigned for health reasons.
29. Rev. William Turner	1906-	In service until the 1950s.
30. Elizabeth Cole	1909-	
31. Ruth Livingstone-Wilson	1914-1920	Married Rev. MacDonald, remained in mission.
32. Hubert Wilson	1914-1929	Resigned.
33. Mary Patrick	1914-	
34. Annie Ferguson	1919-	
35. Rev. David McCulloch Brown	1920-	
36. Nurse E.B. Christie (WFM)	1921-	
37. Nurse Helen Patrick (WFM)	1921-	
38. Nurse I. Reid (WFM)	1921-	
39. Nurse Ruth Service (WFM)	1922-	
40. Nurse Masterton	1922-	
41. John Todd	1922-1932	Resigned, re-appointed 1948.

42. Nurse Coutts	1925-	
43. Nurse Muir	1925-	
44. Nurse Treu	1925-	Widowed volunteer from South Africa.
45. Alexander Guthrie Badenoc	1925-1926	Resigned, converted to Catholicism.
		Medical service in Kuala Lumpur.
46. George Binnie Burnett	1926-1935	Ordained in 1932.

2 Patient statistics, Bandawe, 1884-1890

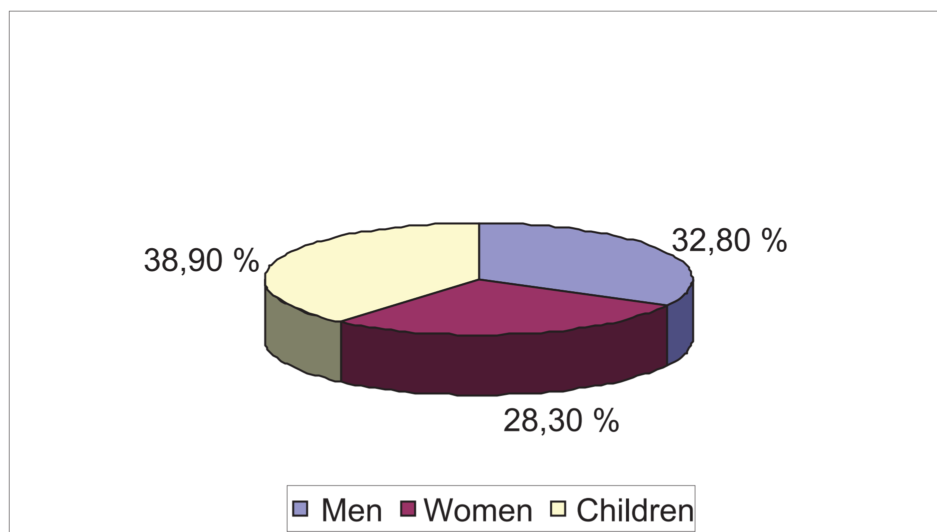

FIGURE 1 Patients by gender and age, Bandawe dispensary, 1884-1890.

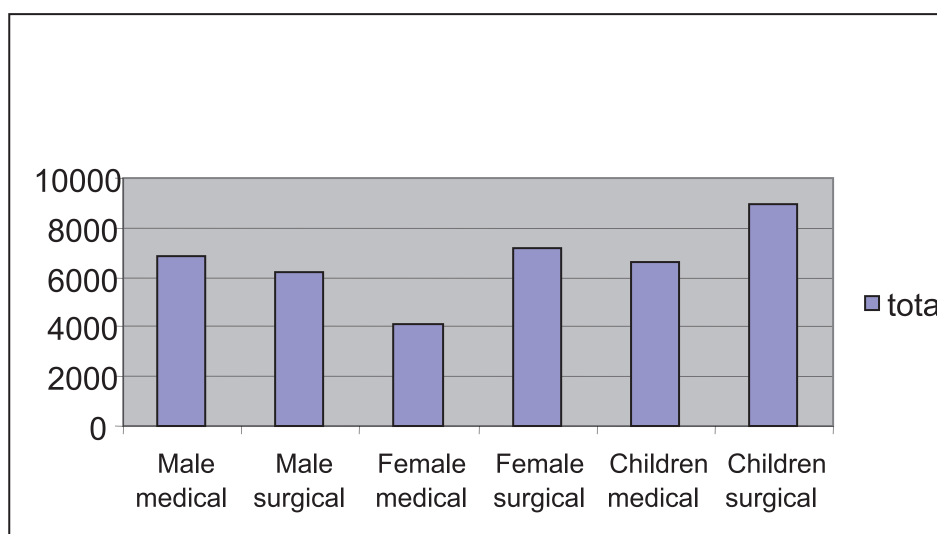

FIGURE 2 Medical and surgical attendances, Bandawe dispensary, 1884-1890.

Total number of patient attendances = 39899

Source: Daily Journal of Livingstonia Mission, MNA 47/LIM/10/2.

3 Case analysis of medical and surgical cases treated for the first time during January-November 1889 in Livlezi Valley.[2]

Medical cases

Fever	*351*
Diarrhoea	*331*
Catarrh and Bronchitis	*232*
Rheumatism	*164*
Colic	*136*
Palpitation and other Heart affections	*45*
Dysentery	*41*
Constipation	*32*
Neurotic Affections	*23*
Indigestion	*18*
Epilepsy	*8*
Paralysis	*2*
Dropsy	*3*
Pleurisy	*1*
Phthisis	*1*
Child-birth	*1*
TOTAL	**933**

Surgical cases

Ulcers and Abscesses	*398*
Skin Diseases	*208*
Itch	*47*
Leprosy	*2*
Eye cases	*118*
Wounds and Cuts	*63*
Bites by Leopards	*2*
Ear Cases	*34*
Inflamed Glands	*14*
Burns	*8*
Bruises	*7*
Swollen Joints	*7*
Odema	*6*
Tootache	*9*
Teeth extracted	*3*
Sprains	*4*
Hernia	*2*
Piles	*2*
TOTAL	**1389**

TOTAL MEDICAL AND SURGICAL CASES 2322

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[2] *Report on Foreign Missions of the Free Church of Scotland for 1889,* p. 58. Compiled by Dr George Henry.

4 Recommended scale of fees for European patients in Livingstonia, 1907[3]

Ordinary visit (at doctor's house or within a mile), 10/6.

Mileage, per mile up to 10 miles, 2/6; after first 10 miles, 1/.

Detention, per half-hour, 10/6; Special visit, 21/; Night Visit, 21/ to 42/.

Sitting up, or sleeping in patient's house, per night, 1 to 1 ½ guineas.

Written prescription (extra), 1 guinea.

Medicines, per 8 oz. bottle (second bottle half-fee), 10/6.

Letter of advice, 10/6; Vaccination, 21/.

Midwifery (ordinary), 5 to 10 guineas.

Anaesthetics (extra), 1 to 2 guineas.

Surgical operations (with anaesthetic), 5 guineas upwards.

Fractures and dislocations, 2 to 5 guineas.

Minor surgical operations, 1 to 2 guineas.

Drawing or stopping teeth, per sitting, 1 guinea.

Testing urine (special), 1 guinea.

Examination of blood (special), 3 to 5 guineas.

Medical examination, 2 guineas upwards.

Certificates, 1 to 2 guineas.

Reports, 2 to 5 guineas.

Staying at patient's house, per day, 1 ½ to 2 guineas.

Boarding at doctor's house, (convalescent patient), including professional attendance, but not operations, medicines, dressings, &c., per week, 3 to 5 guineas.

Do. (acute case), excluding professional attendance, per week, 2 to 3 ½ guineas.

Venereals, ordinary to double fees.

Native officials, half-fees.

Court fees, not determined.

Post-mortem, 10 guineas.

Consultation with another doctor at patient's request, 2 guineas upwards.

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3 Minutes of Mission Council 11 April 1907. NLS, Acc. 7548 D 71, Letters to the Livingstonia Sub-Committee 1907, p. 55.

5 Victorian Scottish surgical instruments

PICTURE 1 A Victorian case of amputation instruments, including bone saw from the 1840s.

PICTURE 2 A pocket case of surgical instruments, used by an anonymous Scottish missionary doctor in Africa.

Photographs: Andrew Connell, RCSed Museum.

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